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Shiatsu practitioners: forging a path through a landscape of practice

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Abstract

This thesis is an exploratory study of Shiatsu as a distinct type of healthcare practice.

Situated within the sociology of the professions as the wider academic context, this study focuses on Shiatsu practitioners and the process of professionalisation in relation to complementary and alternative medicine (CAM). Neo-Weberian theory is used to examine the field of CAM, highlighting its marginalisation by the medical profession. What counts as legitimate knowledge is raised as an important question in relation to the process of professionalisation and CAM.

Ethnography and narrative inquiry form the basis of the methodological approach. My experiences as a Shiatsu practitioner gave me 'deep familiarity' in the field of my research and I examine the challenges in this respect and discuss reflexivity as a methodological tool. The recruitment strategy led to a spectrum of participants' experiences across a broad temporal dimension and I argue this is a particular strength of the study. Concepts of 'social positioning' and 'turning points' provide important theoretical considerations of the analytic framework.

The data-led chapters collectively form a trajectory of participants' pathways through a 'landscape of practice'. These chapters highlight key tensions and turning points in relation to the trajectory of 'Getting into Shiatsu' and 'Getting out there to practise Shiatsu', particularly in respect of the status of knowledge and earning a living as a Shiatsu practitioner. These tensions are discussed in the context of professionalisation, and highlight some of the wider structural factors – for example the interface of Shiatsu with the NHS, other CAM practices as well as society in general. The issue of marginalisation provides a connection between Etienne Wenger-Trayner's concept of landscapes of practice and neo-

Weberian theory in relation to CAM practices. The experiences of participants in this study are potentially relevant to other practitioners not only in other marginalised emerging professions but also practitioners in more established professions.

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Abbreviations

BMA	British Medical Association
CAM	Complementary and Alternative Medicine
CHRE	Council for Healthcare Regulatory Excellence
CNHC	Complementary and Natural Healthcare Council
GMC	General Medical Council
IHC	Integrative health care
MRSS	Member Registered of Shiatsu Society (UK)
NCCAM	National Center for Complementary and Alternative Medicine
NHS	National Health Service
OT	Occupational therapist
PSA	Professional Standards Authority
TCM	Traditional Chinese Medicine

Use of authors' first names

I have used some authors' first names (for example, Mike Saks, Etienne Wenger-Trayner, Ursula Sharma and Gavin Andrews); where I cite their work as a specific reference, I use their second names and year (for example, Saks 2006).

Etienne Wenger recently became Etienne Wenger-Trayner. Any references that pre-date this change of name will appear as Wenger (year) and those that post-date the change will appear as Wenger-Trayner (year).

Nomenclature

The term 'mainstream health care' is used synonymously with 'biomedicine' and 'orthodox health care'.

The term 'health care' is written as two words when used in the context of a noun and as 'healthcare', when applied adjectively.

Healthcare practices for example, Acupuncture, Massage are capitalised unless used otherwise as quoted text.

CHAPTER 1

Introduction

This thesis, comprising six chapters, is an exploratory study of Shiatsu as a distinct type of healthcare practice.

In this first, short introductory chapter, I outline the context for my research and explain the overall structure of the thesis.

My research is broadly situated within the sociology of the professions which provides the wider academic context for this thesis. More specifically, this study focuses on Shiatsu practitioners in relation to the process of professionalisation in the context of the diverse and contested field of complementary and alternative medicine (CAM).

My study aims to address the following research questions:

1. What processes are involved in becoming a Shiatsu practitioner?
2. How do Shiatsu practitioners understand and explain their practice?
3. What are the opportunities and challenges experienced by Shiatsu practitioners in relation to the professionalisation of Shiatsu?

Chapter 2 reviews the literature in relation to the sociology of the professions and draws on neo-Weberian theory to examine the field of CAM, highlighting its marginalisation by the medical profession (Saks 1996). A key question raised in the review is whether professional groups are motivated predominantly by public interest or self-interest (Stone 2002b). This chapter also raises the complex and often controversial question of what counts as legitimate knowledge and discusses the process of professionalisation in relation to CAM (Cant 1996). The review then turns to consider the literature in relation to major stakeholders in

CAM and 21st century healthcare provision. Following a discussion of the literature in relation to research in the field of CAM, the chapter makes the argument for research to go beyond issues of efficacy and the evidence-base in relation to CAM to focus on in-depth studies of distinct groups of CAM practitioners (Sharma 1991). The review concludes by making the case for exploring Shiatsu as a distinct healthcare practice and outlines how my motivation for this study stemmed from my own experiences as a Shiatsu practitioner.

Chapter 3 discusses the methodological and theoretical considerations underpinning my research. The chapter considers ethnography and narrative inquiry as methodologies and discusses how my experiences as a Shiatsu practitioner gave me 'deep familiarity' (Goffman and Lofland 1989) in the field of my research. It discusses the challenges of being both a Shiatsu practitioner and researcher and examines reflexivity as a methodological tool. The chapter discusses the methods used for approaching the field and generating the data, including ethical dimensions. It considers how the recruitment strategy led to a spectrum of diverse participant experiences spanning a broad temporal dimension and argues this is a particular strength of the study. Concepts of 'social positioning' and 'turning points' (Riessman 2001) are introduced as methods of inquiry. The chapter introduces Wenger (1998) and Wenger-Trayner et al.'s (2015) theories in relation to social learning as important considerations in relation to the analytic framework which is developed later in the thesis. Chapter 3 concludes by discussing my reflections on the process of generating the data, and outlining the two ensuing data-led chapters (Chapters 4 and 5) and highlighting a particular approach to my style of writing these chapters.

Chapters 4 and 5 collectively form an overall trajectory of participants' pathways in relation to their turning points and positioning through a 'landscape of practice' (Wenger-Trayner et al. 2015) as generated from analysis of the data.

Chapter 4, 'Getting into Shiatsu', focuses on what experiences drew participants to Shiatsu, highlighting a set of turning points and range of positions in their journeys into Shiatsu. Comprising five parts reflecting the analytic themes in the chapter, it begins by examining participants' 'Voyages of discovery' and then considers the ways in which they supported their own health. The third part signals a turning point in the overall trajectory looking at how participants begin to think of ways in which they might use Shiatsu to support the health of others. Part 4 considers the influences that led participants to sign up for Shiatsu training, and the final part examines participants' experiences during their training.

Chapter 5, 'Getting out there to practise Shiatsu', takes forward the trajectory of how participants forged a path through a landscape of practice. In three parts, which reflect the analytic themes, it first examines how participants positioned their Shiatsu practice, revealing three ways in which they identified themselves as practitioners. The second part focuses on the challenges facing those participants in private practice, highlighting a turning point in relation to setting up in business and earning a living through Shiatsu. The final part examines the ways in which participants explained their practice.

The data-led chapters highlight some key tensions and turning points in relation to the trajectory 'Getting into Shiatsu' and 'Getting out there to practise Shiatsu', particularly in respect of the status of knowledge and how to earn a living as a Shiatsu practitioner.

The final discussion chapter, 'Shiatsu practitioners: forging a path through a landscape of practice', draws together the turning points and tensions highlighted

in the two preceding chapters and discusses them in relation to different theoretical perspectives. Structured in five parts, the chapter first revisits the literature discussed Chapter 2 to examine the key turning points that led to the arrival of Shiatsu in the UK in relation to participants' pathways to practice. The second part outlines the key components of Etienne Wenger-Trayner's theories which had particular relevance to making sense of my data. The next part discusses these theories in relation to participants' pathways to practice and makes the case that the issue of marginalisation provides a connection between the theories of Etienne Wenger-Trayner in relation to landscapes of practice and neo-Weberian theory as posed by Mike Saks, in relation to CAM practices. Furthermore, the issue of marginalisation highlights some of the wider structural factors, for example the interface of Shiatsu with the NHS and other CAM practices as well as society in general. The penultimate part of this chapter includes reflections on my experiences of carrying out this thesis, particularly in relation to my journeys both as a Shiatsu practitioner and researcher. Finally, the chapter draws together the key arguments, outlines limitations and discusses how this work makes a contribution to knowledge with suggestions for further research. I suggest that the experiences of participants in this study are likely to be of relevance to practitioners, not only in other emerging professions in marginalised positions but also by offering insights that may add to our understanding of the process of becoming a practitioner in more established professions.

The thesis now turns to Chapter 2 which begins, as indicated above, by setting out the overall context for my research in the sociology of the professions.

CHAPTER 2

Literature review

Introduction

This review broadly situates my research within the sociology of the professions as this provides the wider academic context for the particular focus of the research questions. The review is in three parts and a critical review of relevant literature identifies a gap which my research attempts to address.

The first part begins with a chronological review of the major sociological perspectives of the professions and addresses the relevant literature in relation to the professionalisation and regulation of the health professions. A key question is whether professional groups are predominantly motivated by public or self-interest and focuses on consideration of the medical profession in this respect. This part examines what counts as knowledge including the rise and dominance of the medical profession.

Part 2 examines the field of Complementary and Alternative Medicine (CAM) highlighting its marginalisation by the medical profession and reviewing the complexity of the CAM field. This part reviews the literature in relation to the major stakeholders in CAM and 21st century healthcare provision.

The final part explores Shiatsu as a distinct type of CAM healthcare practice and specifically in the context of current issues in relation to healthcare professionalisation and regulation.

Part 1 Sociology of the professions

This part first considers some of the main theories in relation to the sociology of the professions and why the medical profession gained a legally supported dominant position in health care in the UK. A key question is whether professional groups are predominantly motivated by public interest or self-interest (Stone 2002b). Until the 1960s, central to the ideology of professions, was the apparent widespread and relatively uncritical acceptance by social scientists that professions served the public interest and it is this ideology that has created a great deal of debate and controversy (Saks 2000).

Social scientist trait and functionalist commentators have historically viewed professions as different from occupations, playing a positive and important role in wider society (Saks 2003a). Early theorists such as Parsons (1951) saw the professions as performing a stabilising function in society. This functionalist view of professions perceived there were particular aspects of a profession – particularly in relation to medicine and law – that were of functional benefit to society. Members of these professions used their distinctive expertise and knowledge non-exploitatively for the public good and in so doing earned a privileged financial and social status (Barber 1963). Thus, the traditional social scientific view of trait and functionalist writers on professions centred on unique bodies of specialised expertise which was considered to be of great value to society and employed in the interests of clients and/or the wider public (Millerson 1964).

Trait writers, whose work focused on drawing up theoretically unrelated lists of professional attributes, found that altruism was one of the most frequently cited characteristics of a profession along with lengthy training, and an esoteric knowledge base (Goode 1960). However, the trait approach has been criticised

for taking for granted the views held by the professions and the associated assumption that a client or patient should fit in with these views. In so doing, this approach ignored the potential for disagreement and conflict between professionals and their clients (O'Donnell 1992).

From the mid-1960s, as part of a wider societal change characterised by a growing mistrust and questioning of authority, a 'medical counter-culture' (Saks 2006, p. 74) grew in which people started to challenge the expert knowledge of medicine (Kelner et al. 2006). Professions, and especially the dominant profession of medicine, were increasingly seen as paternalistic, insufficiently accountable and self-interested (Allsop and Saks 2002). At the same time as public opinion was beginning to turn against professional occupations, sociological opinion too started to shift more fundamentally against the taxonomic approach to the professions (Johnson 1972, Kennedy 1983, Klein 1989).

Critics of functionalist and trait writers included interactionists such as Becker (1962) and Hughes (1963) who were among the first social scientists to subject the knowledge base and altruism of professions to empirical scrutiny arguing that professional ideologies did not reflect the reality of the social world. For example, Becker (1962) noted there were more similarities than differences between high status professionals – such as doctors and lawyers – and workers such as garbage attendants, janitors and prostitutes and therefore questioned why doctors or lawyers should be seen as different from other occupational groups.

Hughes' (1963) work in the chronicling of inter-war Chicago was grounded in the importance of first-hand experience to understand the social world. He suggested that perhaps one way to understand what professions mean in society is to note the ways in which occupations try to change themselves or their image, or both, in the course of a movement to become 'professionalised' (Hughes 1963).

Hughes (1963) defined 'professionalised' as meaning what happens to an occupation, but also what happens to an individual, in the course of training for their occupation.

Drawing on the work of symbolic interactionists, Everett Hughes and George Herbert Mead (see for example, Mead 1934, Hughes 1958), Bucher and Strauss (1961) proposed a 'process approach' to professions that focused on diversity and conflict of interest within a profession and their implications for change (p. 325). This approach represented a move away from the functionalist approach and trait theory which tended to view the professions as largely a homogeneous community whose members shared identity, values, definitions of role and interests and a process of socialisation of recruits which involved inducting them into a common core (Bucher and Strauss 1961). They argued that this kind of focus tended to overlook significant aspects of professions particularly in respect of differing interests within the profession. Instead the process approach posited that there were a number of groups – which they called 'segments' – within a profession which tended to emerge as coalitions with shared values and interests and, in so doing, betrayed a claim for unity (Bucher and Strauss 1961, p. 325). These segments tended to develop distinctive identities and a 'sense of the past and goals for the future' and took the form of social movements (Bucher and Strauss 1961, p. 325). Crucially, Bucher and Strauss (1961) argued that it was the conflict and competition between segments that led to social movement, re-positioning and change within the profession. Bucher and Strauss (1961) suggested that instead of focusing on the 'many identities, many values and many interests' that existed within a profession, a better understanding of a profession was to be gained by focusing on diversity and conflicts of interests within a profession. They saw a profession as 'loose amalgamations of segments pursuing different objectives in different manners and more or less delicately held

together under a common name at a particular period in history (Bucher and Strauss 1961, p. 326). Although medicine was considered to be the archetypal profession at the time, Bucher and Strauss (1961) argued that the model could have been applied to other professions just as pertinently. Bucher and Strauss' (1961) segmentation theory of the professions is also reflected in Bourdieu and Wacquant's (1992) view that it is important to replace 'profession' with 'field' where the field is a 'structured space of social forces and struggles' (p. 243).

Other critics of the functionalist and trait approaches include Marxist and Foucauldian theorists, who argue for a decidedly negative analysis of professions (Saks 2003a). Marxist accounts regard the professions as oppressive organs of the capitalist enterprise. They perceive the professions as serving the interests of the capitalist class (Esland 1980) and in this respect are critical of a definition of profession as being essentially altruistic. With respect to gender, Jones (1994) maintained that the sociology of the professions tended to overlook the question of gender arguing that feminist theory provided a much richer analysis of gendered occupations in health work and the institutionalisation of male dominance ensured female subordination. In contrast, functionalist writers such as Etzioni (1969) attribute the subordinate position of predominantly occupational groups such as nursing to how there is less requirement for expertise and training to perform their role.

However, although interactionalists such as Hughes and Becker were looking beyond the conventional meaning of the term 'profession', Saks (2003b) argues they did not focus sufficiently on the structural location of professions in society. Saks (2003a) suggests that this difficulty is overcome by examining the professions from a neo-Weberian framework. The neo-Weberian perspective is based on the concept of social closure and refers to the process by which

occupations seek to regulate market conditions competitively to suit their needs by controlling eligibility of access (Saks 2003a). Within this framework, professions are perceived as being occupations with a state-supported legal monopoly, which acknowledges the role of educational programmes and the development of ethical codes in the process of professionalisation (Saks 2003a). This perspective highlights the privileged status of the profession but avoids the self-fulfilling assumptions of trait and functionalist writers (Saks 2003a).

Legitimation of knowledge and professionalisation

Part of the exclusionary tactics employed includes the establishment of legitimate knowledge (Allsop and Saks 2002). What counts as legitimate knowledge and how it is used in claiming expertise is an important aspect in understanding the process and theory of professionalisation.

Foucault (1972) considered that all forms of knowledge are intimately related to power relations at all levels of social life. He claimed that in medical accounts of people, which were carried out through the dominant practice of scientific method, the identities of people being studied were invented and represented through the 'gaze' of the investigators (Foucault 1973). He argued that professions such as medicine and law could exercise power and control because they could define and determine what counted as knowledge – in this case scientific knowledge – and this formed the basis of their power (Foucault 1980). By applying the Foucauldian principle to professions, which universally used scientific standards to proclaim the emancipatory nature of their work, the medical profession can be exposed in using the medical 'gaze' (Arney 1982).

Acquiring knowledge that is deemed to be expert or specialised, not only legitimates high status but also provides the means to activate social control strategies (Larson 1977). Such knowledge has key characteristics: it is taught in

an organised way and usually at a university; and it is standardised and accredited, often with scientific anchorage (Larson 1977).

Acquiring specialist knowledge can be described as 'professionalisation' (Siahpush 2000) and is generally perceived as a process involving four main steps: creation of a distinct occupation; standardising the body of knowledge that members of the occupations should master; development and creation of training courses, certification, licensure, and accreditation processes; gaining public support that the claim to higher status is legitimate (Ritzer and Walczak 1986, Hodson and Sullivan 1995).

However, Abbott (1988) argues that at best a notion of professionalisation that focused on association, licensure, ethics code was misleading in that it ignored who was doing what to whom and how. From a social learning perspective, Wenger-Trayner et al. (2015) argue that in relation to professional occupations, the 'body of knowledge' is best understood as a 'landscape of practice' consisting of a complex system of communities of practice and the boundaries between them (p. 13). Etienne Wenger-Trayner's theories in relation to communities of practice will be discussed further in the final chapter.

The authority acquired by scientific knowledge has served to shape the form and expectation of other forms of knowledge creating a sense of legitimacy (Cant and Sharma 1996b). Thus, the standards set by the form of training based on medical professionalisation have established important benchmarks against which to judge other forms of 'knowledges' (Cant and Sharma 1996b). Furthermore, professionalisation is seen as a unique form of occupational control of work that has distinct advantages over market, organisational and bureaucratic forms of control (Freidson 2001).

The type of knowledge, the social and cultural value attributed to it and the way in which each occupation uses that knowledge are seen as central to both the process of professionalisation and maintaining and extending professional positions (Allsop and Saks 2002). The final point is particularly central to the issue of the extent to which professional groups are motivated by self-interest or public interest. Keeping practice up to date and practising safely are crucial aspects of professionalisation (Stone 2002b). Professional practice is measured against a set of standards which are then regulated – in order to ensure that practitioners are competent to practise and work within ethical standards. The regulatory body is part of a network of institutions that validate the wider profession.

Regulation

A professional regulatory body is only one aspect of a profession albeit a key symbol of self-governance. The primary purpose of regulation is to protect the public (Stone 2002b). Healthcare regulation seeks to ensure that practitioners have had appropriate training and are competent to practise and work within ethical standards (Stone 2008). The main premise of professional self-regulation is that professional practice is based on highly technical skills and that as a result, the profession is best suited to set its standards and monitor professional performance against these standards (Allsop and Saks 2002). However, it is increasingly accepted that professions must be accountable to the public and patient – without being unnecessarily burdensome on those being regulated – and public and patient involvement (PPI) is now firmly embedded in regulatory structures and activities (Stone 2002b).

Interest in new approaches to regulation of the health professions was beginning to take place by the late 1990s, as a result of four important trends (Allsop and

Saks 2002). First, the decline in public trust in the traditional professions; second, moves by the Government to change the regulatory structures of health professions while at the same time encouraging the licensing of new professional groups; third, the Government's growing emphasis on multi-professional working and flexible career structures in the health sector, raised questions about traditional hierarchies in the division of healthcare labour; fourth, increasing pressure to harmonise regulatory structures within a global economy and a European legal framework to encourage mobility of labour within the European Union (Allsop and Saks 2002). What emerged was a new partnership between the public, professionals, employers and government to create a self-regulatory base, the extent of which varies from profession to profession (Allsop and Saks 2002). The structures aimed to be more cost-effective, involve greater numbers of lay members to represent the public interest and meet the contemporary criteria of accountability and transparency (Allsop and Saks 2002).

However, Davies (2004) advocated that a stream of sociological research could help understand the realities of contemporary healthcare practice, its ethical and practical dilemmas, the changing nexus of rights and responsibilities and the shifts in professional identity and practice these changes entail. Saks (2005) argues that public interest and professional self-interest are not necessarily in conflict and may be compatible in serving public interest and a new model of professionalisation could evolve that would aim to avoid the pitfalls of the traditional concept of a profession and place greatest emphasis on protection of the public.

Furthermore, reforms in relation to the practice of health professionals have arisen as a result of the Government's formal response to the Shipman Inquiry's fifth report (Smith 2004). The two papers, *Safeguarding Patients* (DH 2007c) and

Trust, Assurance and Safety (DH 2007b), were to be seen as a single programme of action in which 'the overall objective must be to ensure patient safety, and to reassure the public that in future any behaviour by health professionals which puts their safety at risk will be swiftly identified, investigated, and dealt with' (DH 2007a, p. 28). The White Paper, *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century* (DH 2007b), strengthened regulation in a number of key ways: a requirement for all regulated UK health professions to have in place an appropriate scheme of revalidation; governance changes to appointed, not elected membership, with parity of professional and lay members (if not lay majority); and improved accountability of regulatory councils, including annual reports to Parliament.

The structural reforms outlined above reinforced the message that professional regulation is about public safety, and is not about professionals regulating themselves (Stone 2010). Health care across the UK is regulated by a range of different organisations working in a number of different ways. Following the Health and Social Care Act (2012), the Professional Standards Authority for Health and Social Care (PSA) replaced the Council for Healthcare Regulatory Excellence (CHRE) in overseeing the organisations that regulate health professionals across the UK. The PSA oversees statutory bodies, for example the Nursing and Midwifery Council, that regulate health and social care professionals in the UK and assesses performance, conduct audits, scrutinises their decisions and reports to Parliament (PSA 2014). The PSA also sets standards for organisations holding voluntary registers for health and social care occupations and accredits those that meet them (PSA 2014).

Occupational socialisation

During the early 1980s, there was a regeneration of sociological exploration of occupational socialisation, that is, how knowledge and culture are transmitted to new recruits in an occupational setting (Coffey and Atkinson 1994). A new stream of research in the 'new sociology of the occupations and professions' was advocated which aimed to address the everyday realities of work (Coffey and Atkinson 1994, p. 2). A particular focus emerged on gender and 'careered occupations' (Evetts 1994, p. 1). Other studies drew on earlier theorists such as Bucher and Strauss' (1961) segmentation theory. For example, in his study of the relationships between classroom assistants and teachers in a special school for children with learning disabilities, Todd (1994) used Bucher and Strauss' (1961) segmentation theory to show teaching as an example of an occupation comprising groups with unequal access to resources and prestige. In the context of healthcare practitioners, Melia (1987) notes one of the 'abiding problems' of occupational socialisation is essentially associated with differences between the idealised version of work as it is presented to new recruits and work as it is practised on a day-by-day basis by members of the occupation (p. 1). In her study of professional socialisation of nurses, Melia (1987) argued that nurses' experiences of the two segments education and service differed in relation to the idealised, professional notions of these segments.

In the wider context of occupational socialisation, Evetts (2003) argues that the neo-Weberian approach to the analysis of the professions is of limited relevance and considers that concepts of market closure have led to the neglect of other occupational groups. Evetts (2013) suggests that 'it no longer seems important to draw a hard definitional line between professions and other (expert) occupations' (p. 781). Thus, the concept of profession represents a distinct and generic

category of occupational work which is largely achieved through the process of professionalisation (Evetts 2013).

Professionalism

Kuhlmann (2006) argues that the tradition of 'embodied' professionalism, rather seen as an occupational or normative value represented by the a male physician, has now shifted to matters of trust not only externally imposed through regulatory structure but by the introduction of 'public proofs' (p. 607).

However, Freidson (2001) refers to 'professionalism' as existing when an 'organised occupation gains the power to determine who is qualified to perform a defined set of tasks, to prevent all others from performing the work, and to control the criteria by which to evaluate the performance' (p. 12). He argues that professionalism is based on specialised bodies of knowledge and skill that have no coercive power as they stand (Freidson 2001). The power is gained through successfully persuading others – namely the state – that the body of knowledge is of special value to the public (Freidson 2001).

Furthermore, Freidson (2001) suggests that neo-Weberian theory does not develop a 'logic' – a systematic way of thinking that can embrace and order the issues – but focuses on professionalisation within a historic framework.

Although he would agree that the sociology of the professions has become more of a sub-discipline of the broader sociology of work and occupations, Saks (2010) argues that not only does the neo-Weberian theoretical viewpoint continue to have very wide applicability but when appropriately articulated and operationalised, remains the most incisive and empirically fruitful sociological perspective on the professions. Specifically, Saks (2010) argues that neo-Weberian analyses should be applied empirically to more marginalised,

professionalising occupational groups rather than the focus remain a professions-centric approach.

Rise of the medical profession

Based on the work of the German sociologist Max Weber (1864-1920) who originally outlined the concept of exclusionary closure centred on market control (Weber 1968, first published 1922), the neo-Weberian approach takes a much less positive view than the functionalist or trait perspectives and defines professions as how they have a state-supported legal monopoly in the market in which a profession limits access to the group by means of a register (Saks, 2005). In other words, the neo-Weberian analysis takes a more pragmatic approach, acknowledging the role of self-interest of professions but not going so far as to construe this as malevolent or necessarily against public interest.

Mike Saks, a key theorist on professionalisation, (Saks 1992, 1995a, 1995b, 1996, 2002, 2006, 2012), draws on the work of Berlant (1975) in applying a neo-Weberian viewpoint to account for the rise of the medical profession and which having created a market shelter for itself, casts other healthcare practitioners as 'outsiders' or rivals to the medical profession. Prior to the Medical Registration Act (1858), there was no politically supported healthcare practice and as such there existed a consumer culture and pluralistic field of health care in which all practitioners competed on a more or less equal basis (Saks 2006). Therefore prior to the Medical Registration Act (1858), there was no meaningful distinctive orthodox medical health care.

This pluralistic field included a minority of practitioners – surgeons, apothecaries and physicians – who would later form a unified and legally supported group as a consequence of the Medical Registration Act (1858). The Act led to the formation of the General Medical Council (GMC) which laid the foundations of what was to

become the regulatory model for nursing, midwifery and all statutorily regulated professions. The medical profession was granted autonomy by virtue of achieving the support of the state and a mandate to control its own profession (Freidson 1983). This autonomy resulted in the medical profession holding a dominant position in the division of labour of healthcare professions and an ability to control the regulation of other healthcare professions (Freidson 1983).

Subordination and limitation of other health professional groups

Political support from the state was fundamental to the success of the medical profession, as was the developing pharmaceutical industry which enabled the medical profession to subordinate or limit the authority of rivals within the healthcare field. Thus, the medical profession was able to control the market by subordinating other groups in the medical division of labour as either technical aides or allowing them a separate but contained status (Cant and Sharma 1996b). From this standpoint, they used this power to ensure that professionalisation of other health groups took place in a way that best suited their own interests either through limitation or subordination (Turner 1995).

Subordinated professional groups in the UK include midwives and nurses, founded through the Midwives Act 1902 and the Nursing Registration Act 1919 respectively. Also occupations such as Chiropody, Dietetics, Physiotherapy and Radiography were established as subordinated groups by the Supplementary to Medicine Act (1960). Limited groups are exemplified by pharmacists who were established by the Pharmacy Acts in the 1850s and 1860s, dentists by the Dentists Act (1878) and opticians through the Opticians Act (1958). This legislation enabled these groups to establish their own councils modelled on the

GMC, a distinguishing feature of the GMC being the majority of members were practising members of the profession (Stacey 1992, Larkin 2002).

Following the Medical Registration Act (1858), health practitioners who were not state registered could continue to practise under Common Law, but were effectively marginalised, being placed at a substantial legal disadvantage by not being on the medical register (Saks 2006). A structure was thereby generated which granted exclusive rights to state registered practitioners creating a platform for a state controlled or orthodox and effectively dominant, form of health care rooted in scientific orthodoxy (Saks 2006).

What this highlights is the point at which the medical profession 'came of age' (Bakx 1991, p. 22) and how its power-base stemmed from its claim to being able to treat people successfully through adhering to scientific orthodoxy (Bakx 1991). The knowledge base of health practices that lacked scientific orthodoxy were – and still are to some extent – systematically undermined and discredited (Bakx 1991, Cant and Sharma 1999, Saks 2006).

When orthodox medicine was established in the UK on a formal, national basis in the mid-19th century, the field of Complementary and Alternative Medicine (CAM) – although not named as such at the time – came into being as part of a set of marginalised healthcare practices (Saks 1992).

Part 2 Complementary and Alternative Medicine

This part will first examine definitions of complementary and alternative medicine (CAM) highlighting the complexity and controversy of the field. It will then review the literature in relation to the major stakeholders of CAM and 21st century health care highlighting the importance of CAM in relation to bodywork, including an examination of the evidence-base in relation to CAM. This part then considers the

professionalisation of CAM including how this impacts on its relationship with the NHS. Finally, the review discusses research in relation to CAM practitioners.

Defining CAM

Most descriptions of CAM presuppose the dominance of the biomedical paradigm and describe CAM as being external to it. Furthermore, definitions that locate CAM as a 'unified other' imply not only that orthodox provision predominates and that CAM plays a subsidiary role, but that it also has the power to incorporate CAM (Stone 2002b). In countries where Western medical practices are the dominant form of health care – for example, the UK, USA, Australia and Europe – the historical relationship between orthodox and alternative medicine tended to give rise to definitions that reflected this.

For example, The House of Lords report (2000) – which undoubtedly moved the field of CAM in the UK forward (Saks 2003b) – refers to CAM as being a 'diverse set of health practices that are not considered to be part of statutory or mainstream healthcare provision' (House of Lords 2000). In America, the work of the House of Lords was paralleled by the White House Commission which was established in 2000 by President Clinton to report on CAM because of the high level of interest in, and use of, unorthodox medicine (Saks 2003a).

The House of Lords Select Committee on Science and Technology (2000) divided CAM into three categories which highlight the diversity of the field. The first comprising Acupuncture, Chiropractic, Herbal Medicine, Homoeopathy and Osteopathy were believed to have individual diagnostic approaches. The second category was perceived to complement orthodox medicine and included Hypnotherapy, Aromatherapy, Counselling and Massage including Shiatsu and these therapies were not perceived as purporting to embrace diagnostic skills. The third group of therapies were held to have principles opposed to orthodox

medicine and a less convincing evidence base including long-standing health systems of Ayurvedic Medicine and Traditional Chinese Medicine (TCM) as well as Crystal Therapy, Iridology and Radionics. Although the report highlights that CAM is a complex field, it is firmly rendered, in a highly politicised sense, outside of orthodox medicine (Stone 2002b).

The House of Lords (2000) grouping of CAM into three categories stirred up considerable unrest with the CAM field – particularly in relation to group 1 as it seemed to conflate related but distinct issues (Stone and Katz 2005). The first issue related to regulation (only Chiropractic and Osteopathy were statutorily regulated) and the second whether the therapies had an alternative diagnostic approach. Stone and Katz (2005) argue that a desire for self-regulation is not limited to just one group and in this sense the grouping is short-sighted. Many practitioners placed in the second group would argue that self-regulation is important and also dispute that they do not diagnose (Stone and Katz 2005). Group 3 probably gives cause for greatest concern by placing discredited therapies (with no evidence of acceptability to the scientific community) alongside highly respected forms of traditional medicine such as Ayurveda and TCM (Stone and Katz 2005). A further contentious issue is the placing of Acupuncture in the first category when it is also integral to TCM and Ayurveda (Saks 2005).

However, it is widely argued that CAM is a set of diverse health practices and is far from a homogeneous field (Cant and Calnan 1991, Cant and Sharma 1996b, 1996c, Stone 2002b, Saks 2003b, Adams 2007a, Nissen 2010, Gale 2014). Cant and Sharma (1996b) deliberately pluralise the term CAM referring to 'CAMs' to stress their diversity in the sense that each modality has its own history and characteristics. Furthermore, Cant and Calnan (1991) argue that to group all CAM practices under one label is potentially misleading owing to the disparate

nature of the varying practices and also that there are often few similarities between practitioners within one practice.

Some recent studies appear to be veering away from the presuppositional dominant position of the biomedical paradigm. For example, Falkenberg et al. (2012) propose a pragmatic definition that reflects the vast diversity and complexity of factors within the field of CAM: 'Complementary and alternative medicine (CAM) utilised by European citizens represents a variety of different medical systems and therapies based on the knowledge, skills and practices derived from theories, philosophies and experiences used to maintain and improve health, as well as to prevent, diagnose, relieve or treat physical and mental illnesses' (p. 6). However, other studies show there is continuing difficulty in reaching a consensus on the definition of the term CAM due to uncertainty of the positioning of CAM in the contemporary healthcare systems (Gaboury et al. 2012). Umbrella terms such as CAM and integrative health care (IHC) are useful in the context of research, policy making and education and these terms remain the most popular and accepted by far (Gaboury et al. 2012).

The current view of the National Health Service (NHS) is that there is no universally agreed definition of CAM and although there can be overlap between the two categories 'complementary' and 'alternative', it can be useful to make a distinction between these categories in relation to different ways of using them as treatments (NHS 2014). The US National Center for Complementary and Alternative Medicine (NCCAM) makes the distinction between 'complementary' treatments used alongside conventional treatments, and 'alternative' treatments used instead of conventional medicine (NCCAM 2014).

From the perspective of people who use CAM, using pilot data from surveys and journals of undergraduates to explore lay conceptions of the term CAM, Fennell

et al. (2009) concluded that the public may have trouble conceptualising CAM. Bishop et al.'s (2008) review indicates that people who use CAM therapies often perceive the therapy as a healthcare technology or health practice rather than 'CAM' and suggest that CAM users' terminology is incongruent with existing expert-led taxonomies. Bishop et al. (2008) suggest that physicians and researchers need to be aware that patients' views of what constitutes CAM can differ radically from their own terminology and should be chosen carefully to initiate meaningful dialogue with patients and research participants.

Thus, there are complex issues around defining CAM and the boundaries between orthodox and complementary medicine(s) are far from fixed (Saks 2010). The review now examines the major stakeholders in CAM and 21st century health care: people who use CAM; the medical profession; the state, and finally CAM professions.

People who use CAM

Astin's (1998) widely-cited study indicated that CAM users were not necessarily dissatisfied with conventional medicine but sought CAM largely because they found these healthcare alternatives to be more congruent with their own values, beliefs, and philosophical orientations toward health and life. Although CAM is a socially constructed concept which makes it hard for researchers to truly understand CAM use patterns by the public (Fennell et al. 2009), in the last 15 years there has been a substantial number of empirical studies, including both quantitative studies investigating patterns of CAM usage as well as qualitative studies exploring people's experiences of using CAM (Gale 2014). An extensive body of literature now exists examining the demographics of, and reasons why, people are turning to CAM (see for example, Ernst and White 2000, Featherstone et al. 2003, Thomas and Coleman 2004, Esmonde and Long 2008, Long 2008,

Nissen 2008, Bishop and Lewith 2010, Adams et al. 2011b, Ernst and Hung 2011, Fixler et al. 2012, Fries 2013, 2014).

Additionally, Kelner and Wellman (1997) assert that increasing use of CAM reflects a greater number of 'smart consumers' in society, people who are well informed about health-related issues and prefer to use their own personal informed judgements regarding health care (p. 211). For example, based on an omnibus survey, Thomas and Coleman (2004) suggest that 10% of adults in Britain had consulted at least one CAM practitioner in the past 12 months, and 6.4% had used one of the following therapies – Acupuncture, Homoeopathy, Chiropractic, Osteopathy or Herbal Medicine. Furthermore, although adults in each income and social group had used CAM in the previous 12 months, the data showed a positive association between CAM use and higher gross income levels, as well as non-manual social class and more years in education (Thomas and Coleman 2004). Personal recommendation from a friend or relative was the reason given most frequently for choosing a particular practitioner (Thomas and Coleman 2004).

However, a review by Bishop et al. (2008) of just over one hundred studies of CAM use published in peer reviewed UK journals from 1995-2006, has shown some inconsistencies in the literature. Bishop et al. (2008) suggest that people who use CAM tend to be of middle age, higher education and female, and these findings are not disputed elsewhere. However, they found that the evidence concerning whether CAM users have higher incomes is less consistent and is in contrast to Thomas and Coleman (2004). Bishop and Lewith (2010) suggest that CAM users tend to have more than one health condition. They found inconsistent evidence concerning whether CAM users perceive their own health (physical or psychological) to be poorer than non-users (Bishop and Lewith 2010).

In their systematic review, Posadzki et al. (2013) aimed to estimate the prevalence of use of CAM in the UK and suggested that the average one-year prevalence of use of CAM was 41.1% and the average lifetime prevalence was 51.8%. Herbal medicine is the most popular CAM, followed by Homoeopathy, Aromatherapy, Massage and Reflexology (Posadzki et al. 2013). Regarding the expectations of CAM users, Ernst and Hung (2011) found a wide range of expectations. In order of prevalence, these expectations included hope to influence the natural history of the disease; disease prevention and health; general wellbeing promotion; fewer side effects; being in control over one's health; symptom relief; boosting the immune system; emotional support; holistic care; improving quality of life; relief of side effects of conventional medicine; good therapeutic relationship; obtaining information; coping better with illness; supporting the natural healing process; and availability of treatment (Ernst and Hung 2011).

In her qualitative, in-depth phenomenological study with clients and practitioners involved in complementary and alternative medicines Sointu (2013) suggests that complementary and alternative medicines have been found to give rise to feelings of control, empowerment and agency. Furthermore, she argues these feelings emerge through the caring touch of trusted practitioners (Sointu 2013).

It is suggested that CAM has a significant role within self-care (Long 2009) and is often used for chronic or long-term conditions which tend to require ongoing treatment (Artus et al. 2007, Pilkington 2009, Grazio and Balen 2011). It may be that people use CAM as a first line or last resort, depending on the condition and the therapy (Pilkington 2009). It is estimated that over 50% of people who require health care use CAM either in conjunction with, or separate from, conventional health care (Robinson and McGrail 2004). However, in the UK the feasibility of

choice is dependent on accessibility and this is primarily a matter not only of cost but also of health literacy (Long 2009).

Approximately 50% of people inform their GP or other health professional that they had consulted a CAM practitioner (Thomas and Coleman 2004). However, Robinson and McGrail (2004) suggest that the degree to which patients do not disclose their use of CAM to their conventional medical practitioners can be as high as 77% in some studies. The main reasons patients gave for not disclosing their use of CAM were concerns about a negative response by medical practitioners, the belief that practitioners did not need to know about their CAM use, and the fact that practitioners did not ask (Robinson and McGrail 2004).

Thus, people have not rejected orthodox healthcare practices and, whether people seek CAM as a treat or treatment (Bishop et al. 2008), they are in search of 'something' to support their overall health needs (Ernst and Hung 2011). This perhaps suggests a form of 'integrated self-care' in which people choose health care from both orthodox and other forms of health care currently outside the orthodox system in order to best suit their healthcare needs (Peters 2005).

CAM and bodywork

Most literature on bodywork is based on assumptions which regard touch as physical and visible (Ozawa-de Silva 2002). However, Tahhan (2013) suggests that this type of touch stifles the potential for feeling and connection. In their editorial on emotional geographies, Davidson and Milligan (2004) suggest that the most 'immediate intimately felt geography is the body' and is the 'site of emotional experience and expression par excellence' (p. 523). Bondi (2014) introduces the idea of the 'receptive unconscious, which she connects with the building of trust and the concept of rapport (p. 44) as an important aspect of bodywork.

In the sphere of CAM practices, bodies are often understood to reflect and capture feelings which link to a more holistic view of health (Sointu 2006). For example, Baarts and Pedersen (2009) argue that CAM clients experienced enhanced body awareness and valued the supportive attitude of the practitioner as a caring and nurturing individual who respected the integrity and agency of their clients. In her study of practitioners' experiences of learning to communicate, touch and facilitate the healing process for their patients Gale (2011) introduced two concepts in relation to bodywork: listening to body-talk and constructing body-stories. Body-talk expresses the idea that the embodied patient is not a passive recipient of health care, but that the 'body' is able to communicate its distress and its needs whereas the body-story concept highlights the interactional nature of the therapeutic encounter and the profound interrelation between the treatment and case-taking aspects of the practitioner's clinical tasks (Gale 2011).

Sointu (2013) suggests that healing experiences are entwined with the values and ideals that are normalised in the complementary health sphere and emerge through the caring touch of trusted practitioners. However, as Twigg et al. (2011) note, the relations between body workers and their clients are shaped by the wider social and economic context. For example, Oerton (2004) raises issues in relation to the widespread elisions between 'massage and sex work' and how women therapeutic massage practitioners have to mark out their professional distance from clients by deploying professional identifications and by using boundary-setting devices or techniques which act to distinguish them from sex workers.

However, Pedersen and Baarts (2010) note there is very limited established scientific evidence for ways users construct and attribute expertise to CAM

practitioners. Similarly, Sointu (2013) calls for the development of analytical frameworks beyond biomedical ideas of scientific effect which would pave the way for more nuanced understanding into experiences of healing. Perdersen and Baarts (2010) suggest that expertise is embodied and produced by means other than those used in evidence-based knowledge. Furthermore, expertise is constructed by making a clear-cut division between the roles and responsibilities of the practitioner and the user and on the basis of specific training or education that practitioners have achieved.

CAM and the medical profession

Functionalists such as Wallis and Morley (1976) tended to see the professionalisation of medicine which led to the marginalisation of CAM as a rational step towards helping people to have better health and be protected from exploitation. However, Saks (1996) argues that it is debatable whether the tactics employed by the medical profession up to the mid-20th century in side-lining its CAM rivals were in the public interest. Attacks on CAM practitioners included disparaging remarks made in medical journals about lack of scientificity and accusations of fraudulent practice (Saks 1996). From a neo-Weberian perspective, interest-based viewpoint, the medical profession had a vested interest in gaining and sustaining their professional standing by taking every opportunity to belittle CAM practitioners (Saks 2005).

Until 1974, medical practitioners in the UK ran the risk of being struck off the medical register if they collaborated with unqualified practitioners. This effectively kept health practices not rooted in scientific orthodoxy at bay in this respect (Saks 2006). Despite robust scepticism by the British Medical Association (BMA 1986) – which argued that such approaches represented a return to primitive and outmoded practices which can be dangerous – by the mid-1980s, there was a

growing use of various types of 'non-orthodox health care' in the UK not generally available under the NHS (Thomas et al. 1991, p. 207). Even at the time of this first BMA Report (1986) there were a number of GPs practising one or more forms of CAM or interested in becoming sufficiently knowledgeable about CAM to be able to refer patients (Sharma 2003).

The turning point in the approach of the medical community toward CAM – arising as a consequence of public and political pressure – was in the publication of the second BMA report (BMA 1993). In addition to arguing that CAM awareness should now be part of the curriculum for medical students, it also stated that there should be better communication between medical and CAM practitioners and there should be more research into CAM (BMA 1993). This report stressed that it was the moral and professional authority of the doctor to help the public judge the competing claims of CAM (BMA 1993).

Nonetheless, GPs' perspectives towards CAM were various. Some physicians considered that many CAM therapies may appear to be effective through non-specific or placebo¹ effects, and were of the view that in the constrained NHS budget, CAM should not be made freely available (Lewith et al. 2001). However, others, for example Paterson (2000), held a different viewpoint. She proposed that 'For an orthodox practitioner like myself, complementary colleagues offer an alternative to costly hospital referrals or repeat prescriptions, and this is especially valued when ... I think orthodox treatment is unlikely to be effective' (Paterson 2000, p. 48). Furthermore, there were calls by some GPs for a new model for 21st century health care, in which research methods are 'turned upside down' to bring an emphasis to researching individuality, patient preference, empowerment, therapeutic relationship and the patient journey (Peters 2004, p.

¹ An inactive substance or procedure, used in clinical trials, administered to a participant usually to compare its effects with those of a real or active drug or other intervention. Placebos should be indistinguishable in appearance to the active intervention to the participants

194). Such calls have resonance with Davies' (2004) argument, as cited above, in which she advocates for a new stream of sociological research to understand the realities of contemporary healthcare practice.

A small minority of UK physicians viewed CAM as a financial 'con-trick' (Lewith et al. 2001, p. 172). Ernst (2010) argued that the popularity of CAM is patient-driven and most orthodox healthcare professionals have little interest in or knowledge of this area, and many remain sceptical about CAM's therapeutic value. A recent systematic review estimates that CAM is recommended by 46% of physicians and around 10% of physicians are now trained in a CAM therapy (Posadzki et al. 2012). However, Posadzki et al. (2012) noted the poor methodological quality of the surveys cautioning that some of the data was generated between 1997 and 2003 and therefore not necessarily indicative of current referral rates.

CAM and the evidence-based debate

Fierce opponents of CAM dismiss it as 'merely snake oil' (Colquhoun 2008, p. 241) and propose that the proper term is 'alternative' because until it can show that a therapy works – in the scientific sense – then it cannot be considered to be 'complementary'. Furthermore, he argues that if and when that happens, such therapies will then be part of medicine (Colquhoun 2008).

However, Colquhoun's (2008) position serves to highlight the debate in relation to the extent to which CAM should be adhering to scientific orthodoxy to demonstrate its evidence-base. For example, The House of Commons Science and Technology Committee (2010) concluded that the NHS should cease funding Homoeopathy arguing that there was insufficient evidence beyond the placebo.

A critical issue for discussion is the extent to which CAM research should be tied exclusively to the issue of efficacy and effectiveness of treatments (Robinson et

al. 2013). The negative attitude towards CAM in medical circles, accentuated further by ongoing publications in medical journals that disparaged CAM practitioners and their therapies, was probably a factor in preventing funding for research during the 1990s (Saks 2006). An openness to using other research paradigms will enable necessary far-reaching questions about the complexity of the field of CAM to be explored in-depth thus broadening and supporting the search for a clinical evidence base for CAM (Adams 2007b). Funding for CAM research in the UK falls 'woefully short' of the sums allocated in this area in countries such as the USA and Australia (Robinson 2009, p. 328). Additionally, where research funding is made available, it tends to be tied to issues of efficacy (Adams 2007b).

Despite the fact that CAM research activity remains small-scale when compared with the resources allocated to orthodox healthcare research (Adams 2007b), the past 25 years have seen the emergence of a substantial number of peer reviewed journals and burgeoning literature. Additionally, funding programmes and organisations dedicated to investigating and promoting an understanding of CAM are now well established. In the UK, for example, the Research Council for Complementary Medicine (RCCM) was formed in 1986 by a group of researchers from both orthodox and CAM (Robinson et al. 2013). As already highlighted, in the USA, NCCAM was established in 1998, and more recently an International Society for Complementary Research (ISCMR) was founded in 2006.

CAM and the state (UK)

Sharma (2003) suggests that there are two key political questions for the state in respect of CAM: first, the issue of regulation and professionalisation and second, whether CAM should be offered via the NHS.

The Government's position in respect of CAM stems from its response in 2001 to the House of Lords report (2000), where it acknowledged the increased public interest in and use of CAM in recent years and also that CAM can play a part in treating NHS patients (DH 2001). However, the Government was clear that if CAM aspired to be an equal player with other forms of NHS treatment, it must meet the same standards in terms of its evidence base, regulatory structures and diagnostic procedures (DH 2001). This position brings the focus back to issues in relation to professionalisation.

CAM and professionalisation

Cant and Sharma (1996b) argue that the theory of professionalisation has to do, in one way or another, with how knowledge is presented and a claim for expertise is pivotal in the acquisition of trust, legitimacy, autonomy and a monopoly. The analysis of orthodox medicine's professionalisation suggests that it is the way that formal knowledge is organised and transmitted that is most important and, it would seem to matter less about the actual content or use of that knowledge in practice (Cant and Sharma 1996c).

In her study of Homoeopathy and Chiropractic, Cant (1996) uses the sociology of the professions to analyse the strategies undertaken to establish a new form of legitimacy. Professionalisation, and the establishment of training colleges and credentials, was perceived as a catalyst for change and generating greater acceptance (Cant 1996). However, Cant (1996) suggests that the knowledge base of the therapies alone was not sufficient to explain the revival of alternative therapies but it was the enthusiasm of a select number of teachers that created and sustained – at least for a time – collective excitement about alternative medical ideas. Cant (1996) argues that the early students of alternative therapies trusted that their teachers were providing them with a radical new set of ideas.

Cant (1996) suggests that charismatic leadership could only maintain 'internal' legitimacy and that the personal trust of students was not sufficient to sustain alternative revival and attract legitimacy from external sources.

Early training courses – charismatic leaders

The growth of the UK CAM market during the 1970s was exponential and this growth was followed by a mushrooming of CAM colleges and professional associations (Cant and Sharma 1996b). Cant and Calnan (1991) suggest this professionalisation was a strategy to establish 'autonomy, status and a distinctive identity supported by the notion of specialised knowledge' (p. 52). Cant and Sharma (1996a) argue that the advantages of having a professional association with the subsequent establishment of training colleges and credentials, served as a catalyst for change in increasing the legitimacy and acceptance of CAM practices.

Cant (1996) refers to the renaissance of alternative therapies as characterised by a small and diverse group of charismatic people who taught others by apprenticeship or small classes. Weber (1978) argues that charisma is an extraordinary quality possessed by an individual, and on account of this quality, such an individual is treated as a leader. Furthermore, charismatic leaders are obeyed by virtue of the trust that people place in them (Weber 1978). In this model of learning, Cant (1996) suggests teachers encouraged openness and commitment and were less interested in a codified and structured form of knowledge. Cant (1996) found in her study of homoeopaths, their motivation to form a professional body may have stemmed from a desire to 'spread this to people' because of its perceived 'inestimable value' (p. 56). Furthermore, students respected their teachers for their wisdom and trusted their knowledge

(Cant 1996). Thus, following an apprenticeship, students gained 'great confidence' and proceeded to operate in a 'cottage industry' type of practice.

Regulation of CAM

In contrast to some other European countries, in the UK the practice of CAM by non-medically qualified practitioners is not illegal (Stone 2002b). As such, in the UK, CAM therapies can be practised under Common Law, although practitioners are liable in this respect.

As discussed above, the reforms in relation to the practice of health professionals (DH 2007c, 2007b, 2007a) have important implications for CAM practitioners, in terms of how and whether a CAM practitioner is deemed fit for practice (which includes a willingness to engage in regulation and professionalisation) by commissioners of health care, members of the public and policy makers.

Stone (2002a) identified major ethical and legal responsibilities owed by CAM practitioners to their patients, namely in terms of duties to benefit and not to harm their clients. Stone (2002a) highlights how a therapy has the capacity to cause harm when used inappropriately, despite the assumption that it is generally considered to be relaxing, gentle and harmless. Such principles are fundamental to all healthcare relationships, whether CAM or otherwise, and Stone (2002a) concludes that ethical and legal principles go beyond the requirement that practitioners are technically competent and argues that for therapies to grow in credibility, practitioners need to be familiar with and accept their legal and ethical responsibilities (Stone, 2002a). Long et al. (2009) suggest that for safe, professional and competent practice, it is incumbent upon the practitioner to be aware of potential post-treatment reactions, to be sufficiently knowledgeable to distinguish between non-consequential, transitional effects and potentially

adverse effects that may require further intervention, and to be able to advise clients accordingly.

Most CAM therapies now recognise the importance of regulation as a mechanism for protecting the public and are putting regulatory structures in place (Stone 2009). As discussed, professionalisation has been associated with the development of scientific knowledge and promoting the profession (Cant and Sharma 1996c). Furthermore, CAM therapies seeking to professionalise, model themselves on the medical profession and in so doing attach themselves to the scientific paradigm which uses science both to explain how it works and prove that the therapy does work in practice (Cant and Sharma 1996c). However, CAM practitioners who aspire to formal or statutory regulation in the belief that it enhances professional status and respectability suggest that the same fundamental tension between public interest and professional self-interest in relation to professions in general also operates within CAM regulation (Stone 2002b). Although the wording 'promoting the profession' is now being removed from statutorily regulated health professions, many CAM therapies remain fixed in their thinking that regulation, and statutory regulation specifically, would enhance their status (Stone 2009).

Despite the professionalisation of a wide range of professions such as Physiotherapy and Podiatry, attempts by some CAM practitioners to gain professional status were undermined by the strong medical-ministry alliance that existed until the end of the 20th century (Saks 2003a). This is well illustrated in the case of the osteopaths, who unsuccessfully lobbied to gain professional standing in the 1920s and 1930s. Larkin (2002) notes that the medical community repeatedly blocked independent registration of Osteopathy on the

basis that the theory that conditions such as colds, gout and measles could be due to small spinal irregularities was unfounded.

Despite substantial internal rifts (Fulder 1996), Osteopathy became a statutorily regulated profession following the passing of a private member's Bill leading to the Osteopaths Act (1993). The Chiropractors Act (1994) followed shortly afterwards. Some therapists were not prepared to join the register, perceiving regulation as an unwarranted restriction of their autonomy (Price 2002). In the case of Osteopathy, practitioners who refused to register, continued to practise as 'osteomyologists' or 'cranio-sacral practitioners' as the title of Osteopath was now protected by the Osteopaths Act, 1993 (Price 2002).

O'Neill (1994) argues that the statutory regulation of Osteopathy and Chiropractic was a consequence not just of these therapies adopting the model and scientific orthodoxy of the medical profession but also that the therapeutic techniques had been adopted by orthodox practitioners. However, the Government's position in relation to CAM and regulation is one of a light touch which should be proportionate to the risk posed (Stone 2002b). There has been a notable shift in the last ten years towards establishing better regulatory structures for CAM therapies (Clarke et al. 2004, Dixon et al. 2007, Baer 2010, Waller and Guthrie 2013, Granger and Watkins 2014) .

The Complementary and Natural Healthcare Council (CNHC), funded by the Department of Health and facilitated initially by The Foundation for Integrated Health, opened its register to CAM practitioners in 2009 as a voluntary, federal register for twelve CAM therapies. Its function is to make available to the public a list of CAM practitioners who have been assessed, by their respective professional bodies, as meeting national standards of competence and practice (CNHC 2010, 2013). Registration with the CNHC is currently voluntary and the

CNHC acknowledges that not all CAM practitioners from the currently registered disciplines will have registered with the CNHC (CNHC 2010). The CNHC (2010) suggests that this does not necessarily mean that these practitioners are not qualified, but it does mean that the CNHC knows nothing about their qualifications or experience. The CNHC continues to open its register to more CAM disciplines. Until the formation of the CNHC in 2009, the position in respect of regulation of most CAM practices was that of a largely fragmented and disparate set of arrangements across most CAM practices. The Government is advising GPs, who have patients seeking to use a CAM therapy, to recommend only CAM practitioners who are registered with the CNHC (DH 2010).

Stone, a key proponent of the CNHC, argues strongly that 'With appropriate regulatory safeguards, CAM practitioners have so much to offer the self-care, mental health and long-term conditions agenda which underpins health care. Without it, practitioners may find themselves left out in the cold' (Stone 2010, p. 2). However, she also notes that although the willingness of practitioners to register for CNHC is not known, it would appear that it is only a minority of people who are registering (Stone 2009). One possible issue might be cost as many CAM practitioners work part-time and do not enter the profession for a salary (Sharma 1991, 1992, Andrews and Hammond 2004). Some CAM practitioners assert that offering a high level of service in their CAM practice need not depend on being affiliated to an organisation and the duty to act ethically is an individual responsibility (Stone 2002a). In a similar respect, a key question raised by Davies (2004) is how to sustain, on an individual level, the professional values that have stressed altruistic concern for the patient, dedication and a commitment to the work.

The extent to which CAM practitioners become professionalised impacts on the use of CAM by the NHS (Saks 2006) and as Stone (2002b) argues, NHS commissioners are necessarily cautious about introducing services that are not deemed to be safe or cost effective.

CAM and the NHS

The Government's (DH 2001) position in relation to provision of CAM within the NHS was in agreement with the House of Lords (2000) for the need for strong evidence beyond the placebo effect to support the use of CAM therapies in the NHS. However, it conceded that it must be for the NHS clinician or healthcare practitioner with lead clinical responsibility for the individual patient to judge whether, when and how an individual patient could benefit from the use of a particular therapy (DH 2001). The House of Lords report (2000) recommended the incorporation of CAM into the training of medical practitioners as well as other statutory healthcare practitioners in order that they are sufficiently familiar with the field of CAM and are able to advise their patients (House of Lords 2000).

CAM provision via the NHS is patchy and unsystematic (Sharma 2003). Andrews (2004) suggests that in the UK there is a small but increasing number of therapists directly funded by public finance and work within the NHS in both hospital and community-based settings. These people comprise a mix of CAM practitioners with no other role within the NHS and NHS practitioners who also practise a CAM therapy (Andrews 2004). The majority of UK CAM therapists earn a living through private practice via fee-paying clients (Andrews 2004). Some studies indicate increasing use of CAM by other healthcare practitioners (see for example, Andrews 2003, Smith 2008, Johannessen 2009, Mackereth et al. 2009, Lorenc et al. 2010, Hall et al. 2013). The incidence of nurses and midwives incorporating CAM within their practice has emerged in discrete areas (Adams

2006, Tovey and Broom 2007). Where NHS authorities or Trusts are providing CAM, for example within pain clinics in hospitals, it tends to be on an ad hoc basis, not necessarily based on evidence, but as a result of strong, local advocates forging good community relationships (Heller 2005). Other studies outside of the UK suggest that integrating CAM therapies within mainstream health care depends on collaborative working relationships (Barrett et al. 2004, Moritz et al. 2005). Although now over ten years since its publication, Thomas et al's. (2003) study, which showed that the proportion of general practices providing some sort of access to CAM rose from 39% in 1995 to 50% in 2001, remains the most recent UK study in relation to NHS referrals to CAM practitioners. One or more members of a primary healthcare team provided therapies in an estimated 29.5% of practices; independent CAM practitioners worked in 12.2%; and 26.8% of practices made NHS referrals to external CAM providers (Thomas et al. 2003).

A shift toward integrative medicine (Peters 2005) and the development of integrative healthcare settings combining various aspects of Western biomedicine and complementary/alternative medicine, meant research has turned to focus on examining patterns of interactions between biomedical and CAM professions (Hollenberg 2006). However, while IHC is recognised internationally and occurs in many different contexts, for example clinic or hospital, patterns of interaction between biomedical and CAM practitioners, and the nature of IHC settings, are largely unknown (Hollenberg 2006). The findings from Hollenberg's (2006) study in Canada suggest that when attempts are made to integrate biomedicine and CAM, dominant biomedical patterns of professional interaction continue to exist. Cant et al.'s (2012) recent study reveals that although attempts to integrate CAM had some initial success – underpinned by the enthusiasm of individual practitioners and a relatively permissive organisational context – this was

followed by a decline in service provision. Furthermore, the fact that the services were established by individuals left them vulnerable when more restrictive funding and governance regimes emerged (Cant et al. 2012). These findings are illustrated by Tarr (2011) who argues that while the embodied practice of Alexander Technique has much to offer to mainstream health care, the discourses and knowledge systems in which it is embedded make it unlikely to receive mainstream medical acceptance.

In the context of research methodologies, Wye et al. (2009) urge that there is a need to improve the quality of evaluations of CAM services by using standardised health outcome tools and the use of statistical analysis in this respect. However, Sharma (2003) suggested that there was a need to expand the framework in which the dominance of orthodox medicine provided the context for research.

Researching practitioners

Sharma (2003) also suggested that it is time to move beyond asking the generic question 'Why do people access CAM here and now?' (p. 214) highlighting the focus on CAM practitioners. Andrews and Hammond (2004) take this point further in relation to practitioners, arguing that it is necessary to take a more sensitive and individualised approach to investigating CAM practice. They suggest 'an obvious line of inquiry' is to investigate specific modalities or CAM practices which may differ in their regulation, practices and connections with statutory health sector practices (Andrews and Hammond 2004, p. 49).

As suggested previously, social scientific studies of the health professions have tended to focus on fully-fledged professions, mainly the medical profession (Parry and Parry 1976, Waddington 1984). Saks (2010) suggests this is not surprising as this profession operates within clear boundaries and is well organised – which are aspects of professionalisation – and there is a range of professional literature

on which to draw. In contrast, social scientists have largely failed to bring CAM within their critical gaze, focusing more generally on the disjunctions between lay understandings of health and illness and those of the biomedical clinic (Cant and Sharma 1996b) and using the concept of medical dominance as the starting point (Sharma 2003). CAM sociological studies therefore have been largely treated as 'inhabitants of cultural sidelines and traditional backwaters' (Cant and Sharma 1996b, p. 2).

As discussed earlier, the focus is now shifting in relation to the sociology of professions to that of work and occupations more generally with more public accountability in relation to trust (Kuhlmann 2006, Evetts 2013). Although CAM largely remains outside of the statutory healthcare system, boundaries are now less distinct with the development of IHCs and patchy provision of CAM (Cant et al. 2012). Despite this trend little is known about CAM delivery – either by statutory health care or CAM practitioners – particularly at a grass-roots level (Adams et al. 2011a). Nationally, the CAM sector remains one of small private businesses, essentially a cottage industry which raises a potential tension between commercial interest and professional altruism (Sharma 1992, Andrews et al. 2003).

Questions about the motivation and background of those who become practitioners, the types of relationships they aim to establish with their patients, how they deal with the day-to-day exigencies of medical practice are best addressed through in-depth research – for example, in the ethnographic tradition (Sharma 1991, Cant and Sharma 1995). More research is needed beyond survey instruments that uses qualitative techniques such as diary methods and in-depth interviews to capture the lived experience of the user (Adams 2007a). Nonetheless, the extent to which CAM adheres to scientific orthodoxy is still a

contentious issue for some CAM researchers. For example, Ernst (2005) argues that a body of evidence on issues such as why patients use complementary treatments, who uses complementary medicine, how people might use this approach, is inconsequential and that CAM is being turned into 'complementary sociology' (p. 443). Although there is a paucity of research in relation to CAM practitioners, there have been a number of studies to date.

An early study by White and Skipper Jr. (1971) which examined how and why individuals become chiropractors, suggested that Chiropractic was a large part of their early family life and they found that most participants were involved in a serious illness or injury that was not treated successfully by an osteopathic or a medical doctor but was by a chiropractic physician. The first 'formal' research and initial recognition of CAM practitioners was commissioned by the Osteopathy Association of Great Britain (Burton 1977). This research focused rather narrowly on the structure of Osteopathy practices and in particular discussed the age and experience of osteopaths. Fulder and Munroe (1985) made the first serious attempt to estimate the growing number of CAM therapists in the UK, trends in the growth of therapists in the UK, the most common forms of CAM and the number of GPs practising CAM in the UK. White et al. (1997) surveyed the working practices of CAM practitioners, focusing on fee levels and attitudes of CAM practitioners to working in the NHS.

In contrast to survey methodology, Cant and Calnan (1991) explored therapists' experiences and perceptions of orthodox medical practitioners. In her in-depth interviews with thirty-four CAM practitioners in a Midlands locality, Sharma (1991) explored motivation to practise, and suggested that practitioners fell into two categories. Firstly, practitioners reported a 'high level of interest in people' and a satisfaction in helping them to heal, and secondly, a 'tendency to occupational

individualism' or 'preference for autonomy' or 'working outside hierarchical structures, for independence in everyday work' (Sharma 1991, p. 13). The findings in the first category are supported by Nissen's (2010) ethnographic study which showed that motivations to embark on a career in Western Herbal Medicine (WHM) are grounded in an interest in natural healing and the desire to help others. The findings in Sharma's (1991) second category tend to suggest an unwillingness by practitioners to become part of a heavily bureaucratic organisation such as the NHS and are supported by Gibson's (2004) ethnographic study on work and its meaning among alternative health practitioners, in which she showed that, particularly for women, CAM practitioners are moving away from heavily bureaucratised workplaces. In contrast, Andrews (2004) found that an overwhelming majority of respondents (n = 299, 73.2%) expressed a positive response to working within the statutory health sector either in primary or secondary settings. Andrews et al. (2003) showed that CAM therapists generally identified with being carers first and business people second, and this was reflected in their decisions to practise.

However, Peter et al. (2009) suggest that motivational factors for therapists working in cancer care/supportive and palliative care were varied and highlighted a combination of 'push and pull' factors, particularly for therapists who are also healthcare practitioners. Tyreman (2011) argues the development of IHCs has had a number of consequences including for example, how both CAM and what he terms 'Conventional and Orthodox Medical' (COM) professions have had to reappraise their professional identity. Tyreman (2011) questions whether CAM therapies should be considered as distinct professions or – perhaps reflecting Colquhoun's (2008) position as discussed above – be absorbed into the broader field of 'Medicine' or 'Health Care' as adjunctive therapies. Furthermore, Tyreman (2011) suggests that the values commonly identified as being held across CAM

professions – offering natural treatment, being patient rather than disease focused and being holistic – inform good practice. This has implications for establishing professional identity and codes of practice (Tyreman 2011).

In their Australian study of non-mainstream practitioners from five traditional systems of medicine – Traditional Chinese Medicine, Ayurveda, Naturopathy, Homoeopathy and Western Herbal Medicine – Wiese and Oster (2010) examined how these CAM practitioners responded to the adoption of their traditional medicine therapies by the mainstream healthcare system, and the practice of these therapies by mainstream healthcare practitioners. They identified four main conceptual categories: losing control of the CAM occupational domain (the participants' main concern); personal positioning; professional positioning (the core category); and legitimacy (Wiese and Oster 2010). These categories formed the elements of the substantive theory of 'becoming accepted' as a legitimate healthcare provider in the mainstream health system, which explained the basic social process that the study's participants were using to resolve their main concern (Wiese and Oster 2010, p. 415). In their US study, Barrett et al. (2004) found that CAM practitioners wanted to work with physicians and other conventional healthcare workers in seeking a holistic, accessible, patient-centred, integrated healthcare system.

Both as practitioners and consumers, women are more likely than men to engage with CAM and holistic spiritualities (Keshet and Simchai 2014). In her study exploring women's motivations for pursuing training in CAM, their experiences of learning and their visions of future practice, Flesch (2010) found that although female students conceive of themselves as pioneers in the field, they also feel constrained by family and relationship obligations, suggesting that there may be female-specific challenges in relation to learning, and ultimately practising,

complementary medicine. Keshet and Simchai's (2014) review of women CAM practitioners identified three major trends: women draw on traditional female resources and perceived 'feminine' characteristics; the realm of CAM and holistic spirituality challenges power relations and gender inequalities in health care, wellbeing, and employment, and may serve as an emancipating, empowering alternative. However, factors such as lack of political support, legitimacy, and a solid institutional base for the field of CAM and holistic spirituality, and its use by predominantly white middle- and upper-class women, work against significant change in the realm of health care and limit gendered social change. They suggest that the empowerment women experience is a form of feminine strength and personal empowerment that stems from power-from-within, which is not directed toward resistance (Keshet and Simchai 2014).

However, despite the expressed demand for CAM services in developed countries, little is known about the CAM workforce in terms of supply and composition which has direct implications for health policy and the healthcare workforce (Leach et al. 2014). Using data pertaining to the size and characteristics of the CAM workforce from the Australian, New Zealand, Canadian, UK and US Censuses of population, Leach (2013) described the CAM workforce across five developed countries to better inform the health workforce and health services planning. Of the nine CAM disciplines explored, the data showed that Massage therapy was consistently the predominant therapy provided by the CAM workforce, followed closely by Chiropractic (Leach 2013). As is consistent with other literature, they found that across the broader CAM workforce, practitioners were typically female, aged 40 years or more, worked within a primary care setting, held a vocational or higher education level qualification, worked full-time, and earned less than \$1000 (AU) gross per week (Leach et al. 2014).

Andrews (2004) argues that the next step for research is to explore these issues in greater depth, and in particular, to home in on specific CAM practices. Two ethnographic studies which have focused on specific therapies include Gale (2008) and Nissen (2008). Gale's (2008) study of student homoeopaths and osteopaths showed that patient empowerment in a more equitable practitioner–patient relationship of clinical interaction is a useful point of departure for critically exploring issues in the patient–practitioner relationship in an educational context. Nissen (2008) claims that Western Herbal Medicines both enrich and transform personal lives and healthcare practices and demonstrate tensions between gender, power and social change.

This part has shown that despite increasing use and practice of CAM, little is known about CAM practitioners. The move toward integrated health care and changes in regulation suggests that there is a need to understand more about CAM practitioners. Given the disparate nature of CAM therapies, I argue that taking an ethnographic approach to explore a specific therapy in-depth will provide better understanding of that practice.

The final part now examines Shiatsu as a distinct type of CAM healthcare practice.

Part 3 Shiatsu – a distinct healthcare practice

In this final part, I consider the origin and practice of Shiatsu as a distinct CAM healthcare practice. First, I outline its origination from Japan and how Shiatsu originally came to the UK. I then discuss the evolution of the professional organisation of Shiatsu in the UK, the subsequent evolution of the first UK Shiatsu training schools and outline the philosophical theories of Shiatsu. I then discuss definitions of Shiatsu, indicate the extent of use of Shiatsu, and consider

the research and evidence base. Finally I discuss the basis of my research and indicate my research questions.

Shiatsu and Japan

Shiatsu originates from Japan, having evolved from a 'fragmented lineage from the diagnostics of Koho Anma²' and the specialised touch of Anpuku, combined with other influences by innovative 20th century practitioners from Eastern philosophy, traditional methods of self-healing and Western anatomy and physiology (Kishi and Whieldon 2011, p. 17).

During the first decade of the 20th century, although it became illegal to practice Anma without an official licence in Japan, practitioners circumvented the legislation by choosing another name for the manual therapy they practised (Kishi and Whieldon 2011). One such name was Shiatsu which literally meant 'finger pressure' which potentially covered any number of manual therapy methods without pointing to any one in particular (Kishi and Whieldon 2011). The publication of Tenpeki Tamai's book, *Shiatsu-Ho* (Shiatsu Therapy), is largely accredited as an important milestone in the development of Shiatsu in 20th century Japan and which led to growing public and professional interest. Although there was no one clearly defined method of Shiatsu, throughout the 1920s until the post-second world war period, the Japanese people tended to learn and practice Shiatsu informally through reading books. Some practitioner training existed, largely through apprenticeship-type models. In contrast, Anma, being licenced, was taught in Government-sponsored training schools. However, there was an increasing unease by some Shiatsu practitioners about its connection to Anma and other manual therapies and there were moves to define Shiatsu in more scientific terms. Although the post-second world war Allied

² Traditional manual therapy of Japanese using meridians and Anpuku (manual hara treatment)

administration in Japan banned non-licensed traditional Japanese medicine, in the context of the need to only award codified licences in a common lexicon based on the dominant narrative of science, the administration gave time and resource to develop scientific evidence that Shiatsu was different to Anma. However, Shiatsu was still generally perceived as an art practised by individual masters who taught their students in close, personal transmission, which meant that their teaching of it died with each master (Kishi and Whieldon 2011). Thus, the challenge of defining Shiatsu in a scientific framework highlighted the tension between scientific objective textual authority and subjective individual authority mirroring the tensions discussed above.

Eventually, through aligning and embedding Shiatsu with the framework of Western medicine (for example, describing point locations by their anatomical locations rather than according to meridians), Shiatsu was officially recognised by the Japanese Government in 1964, so distinguishing it from Anma (Beresford-Cooke 2003, Lundberg 2014). Official recognition of Shiatsu in Japan is generally attributed to Tokujiro Namikoshi (1905-2000) who established the Shiatsu Institute of Therapy in Hokkaido in 1925 and the Japan Shiatsu Institute in 1940 (subsequently renamed the Japan Shiatsu College) (Jarmey and Mojay 1999). The Japan Shiatsu Institute became – and remains as the Japan Shiatsu College – the only school to receive an official licence to teach Shiatsu and as a result, the Namikoshi method remains the most widely studied method in Japan (Beresford-Cooke 2003). Shizuto Masunaga (1925-1981) studied with Namakoshi and taught at the Japan Shiatsu College for ten years. A professor of psychology at Tokyo University, Masunaga combined his interests of psychology, Western physiology and traditional Shiatsu to develop a particular style of Shiatsu known as 'Zen Shiatsu' (Jarmey and Mojay 1999, Beresford-Cooke 2003). Zen Shiatsu practice involves the practitioner being at one with the person receiving

Shiatsu by developing a Zen-like quality of concentration requiring a development of mu-shin or innocent mind (no ego) (Kishi and Whieldon 2011). According to Kishi and Whieldon (2011), this is an active process and not to be confused with meditation; Shiatsu is performed with this empty mind rather than from theory.

Shiatsu and the UK

As discussed earlier, people turning to health practices outside of statutory provision was a consequence of the 'medical counter-culture' (Saks 2006, p. 74) which represented a growing interest in, and move toward, seeking different approaches to health. From the 1970s, as part of a growing medical counter-culture (Saks 1996), Shiatsu began to appear in other countries outside Japan, for example Europe, USA, UK and Australia.

Many of the early Shiatsu teachers were Japanese either from Japan or the USA. For example, Tokujiru Namikoshi, Shizuto Masunaga and Wataru Ohashi were all influential figures in introducing Shiatsu to Europe, Australia and the USA. Zen Shiatsu was predominantly the kind of Shiatsu practised during the 1970s. No specific Shiatsu school existed in the UK in the 1970s apart from the East-West Centre, a Macrobiotic school and a centre based in London that taught 'Namikoshi Shiatsu' together with Macrobiotic theory³. The East-West Centre – now closed – held cooking classes and Shiatsu workshops, included a bookshop and restaurant. It served as a meeting place for those interested in alternative forms of health (Adams 2002).

During the late 1970s, there existed a loose association of people interested in developing and teaching Shiatsu in the UK (Beresford-Cooke 2003). Comprising

³ Macrobiotic theory, attributed to George Ohsawa (Yukizaku Sakurazawa, 1893-1966), essentially purports that living harmoniously with natural phenomena together with a particular emphasis on a diet of locally grown, seasonal vegetables, leads to a healthy and longer life (Ferré, C. (2011) *Essential Guide to Macrobiotics*, 2nd ed., California: George Ohsawa Macrobiotic Foundation).

mostly those who had initially studied Shiatsu and lived in Japan, these people often gathered together and exchanged ideas (Beresford-Cooke, 2003). However, Kishi and Whieldon (2011) note that although many Westerners had experienced Masunaga's teaching, few had benefited from some personal contact or mentoring as this was largely denied to foreigners. Furthermore, Masunaga's teaching style was difficult to grasp even for Japanese-speaking students thus making it almost impossible for non-Japanese students to study Shiatsu with him (Kishi and Whieldon 2011). Kishi and Whieldon (2011) argue that there was an 'uncertain export' of Masunaga's Shiatsu to the West as a consequence of the lack of translated versions of his work (p. 43). The exception is Masunaga and Ohashi's book, *Zen Shiatsu: how to harmonize Yin and Yang for Better Health* translated by Wataru Ohashi and Pauline Sasaki in 1977. This book represents just a small fraction of Masunaga's lifetime work in Shiatsu yet it has had a disproportionate influence on Western students (Kishi and Whieldon 2011).

Professional organisation

Shiatsu is one of the 15 therapies currently registered with the Government-funded, federal voluntary register CNHC. There are currently two established professional bodies for Shiatsu in the UK: the Shiatsu Society (UK) and the Zen Shiatsu Society. The Shiatsu Society (UK) and the Zen Shiatsu Society are both registered with the CNHC⁴ and as discussed above, the CNHC is accredited by the PSA.

In Europe, Shiatsu has been practiced professionally for about 40 years. While its practice is allowed under common law in the UK and Ireland, in the rest of Europe Shiatsu is tolerated, but without recognition; in no country is there

⁴ CNHC registrants March 2015: total number of registrants, 5159 of which 92 practice Shiatsu (figures supplied by CNHC). Shiatsu practitioner membership represents less than 1% of total Shiatsu Society (UK) membership.

integration into state healthcare systems (Long 2008). Shiatsu is one of the eight disciplines named in the Collins Report, adopted by the European Parliament in 1997, which called for steps to regulate complementary therapy practice and for more research (EP 1997).

Formation of the Shiatsu Society and training schools

The Shiatsu Society (UK) was established in 1981, by a small group of Shiatsu practitioners and teachers as part of the European Shiatsu Federation. In the same way as other CAM practices (see for example, Cant's (1996) study of Homoeopathy and Chiropractic), the Shiatsu Society (UK) modelled its structure on other health-related professional bodies, for example, documenting a set of rules and regulations (code of conduct) and creating a baseline syllabus. One of the first UK training schools to be established was the British School of Shiatsu-Do in 1983 (Adams 2002).

Although largely based on purportedly Masunaga's influence, different styles of Shiatsu were taught. For example, Sonia Moriceau (1959-2013), was reputedly one such teacher with her own style – integrating Shiatsu with Mindfulness meditation to create a unique approach which she called 'Healing-Shiatsu'.

There are currently many styles of Shiatsu including for example, Zen Shiatsu, Movement Shiatsu, Classically-Based Shiatsu, Healing Shiatsu, Barefoot Shiatsu, Quantum Shiatsu, Tao Shiatsu, Ohashiatsu and the differences between these styles is much debated in professional journals (Beresford-Cooke 2011).

Current provision of Shiatsu training courses in the UK

The Shiatsu Society (UK) is the largest Shiatsu professional body in the UK and 'represents all styles and the majority of Shiatsu practitioners, schools and students in the UK – promoting their work and professionalism' (Shiatsu Society 2014). The Shiatsu Society (UK) promotes itself as providing a network linking

interested individuals, students, practitioners and teachers, fulfilling the role of a Professional Association for Shiatsu Practitioners.

It has a total membership of approximately 1000 practitioners including students, practitioners with MRSS⁵ status, teachers and members as shown in Table 1 below:

Table 1 Membership of the Shiatsu Society (UK)

	Total number of members	Males %	Females %	Students %	MRSS %	Teachers %	Mentors %
October 2013	1095	26.5	73.5	22.0	42.5	8.9	6.4
December 2014	1070	24.5	75.5	22.0	43.1	9.2	6.4

(Source: Shiatsu Society (UK), December 2014)

The gender ratio of students and practitioners registered with the Shiatsu Society (UK) as shown above, reflects the general profile of CAM practitioners as predominantly female (Flesch 2010). In relation to age, although no data were available from the Shiatsu Society (UK), drawing on Harris and Pooley’s (1998) survey of 288 Shiatsu Society members, Adams (2002) notes how as a 28-year old student-practitioner he was younger than the mean of 42.6 years and that being male, he was in a minority where 73% of members were female.

The Zen Shiatsu Society appears to have a smaller membership (UK and overseas) of around 150 practitioners. Its charter is to support ‘... students,

⁵ MRSS stands for ‘Member Registered of the Shiatsu Society’. It represents a post-graduate status. There are currently two routes to becoming MRSS: either by undergoing a practical examination by approved Shiatsu Society teachers or by successfully completing a set of practical and theoretical requirements within a specified time.

practitioners, and teachers of Zen Shiatsu in their practical, personal and spiritual development' (Zen Shiatsu Society 2014).

There are currently 34 UK schools providing Shiatsu training of which 32 are affiliated with the Shiatsu Society (UK). Training normally takes place over a three-year period (part-time) according to a baseline syllabus⁶, covering the skills, practice and theory as set out by the professional body. Typically, Shiatsu tuition is provided as part-time, non-residential weekend courses⁷. There are currently several options for training ranging from one-off workshops to full three-year Practitioner Diplomas.

The structure of training programmes varies slightly in different schools but most will include a 'foundation course' comprising three to six weekends for students seeking basic skills of Shiatsu for use on family and friends. Usually the first year will run consecutively from the foundation course. Thus a typical three-year programme might be structured as follows:

- Foundation course – three weekends
- Year one – ten weekends
- Year two – fourteen weekends
- Year three – eleven weekends plus perhaps an extended weekend residential.

The three training years usually run consecutively unless student numbers are too few in which case a study programme may be delayed until sufficient students are enrolled to make it economically viable to proceed. Students are usually able to 'take time out' between courses if desired.

⁶ Please see Appendix 01 – Baseline syllabus

⁷ Information gathered via the Shiatsu Society (UK) website: <http://www.shiatusociety.org/shiatsu-schools> [accessed 5 March 2015]

Shiatsu theory and practice

Theories

Shiatsu draws on the theories underpinning Chinese medicine: namely 'Yin-Yang' and 'Five Element'. The theories of Yin-Yang and Five Element are complex and highly developed. To help set the cultural context and illustrate how they are linked to Shiatsu practice, synopses of these theories – and the concept of 'meridians' – are outlined in the appendices⁸. As indicated in the baseline syllabus, students are taught the 'core theory' underpinning Shiatsu practice.

Hara 'Sea of Ki'

The hara is central to humanity – the mind, spirit and body – and represents the heart of Japanese sensibility, culture and identity; it is both vital and ordinary to traditional Japanese culture (Kishi and Whieldon 2011). Shiatsu is rooted in Eastern traditions of bodywork which means that it shares similarities with Eastern martial and healing arts (Yates 2006). Essential to all martial and healing arts is the development of a 'potent centre of energy' (Beresford-Cooke, 2003, p. 2) located in the abdominal region. Historically, during the Edo period (1603-1867) the samurai⁹ were trained to practice Zen and Taoist meditative techniques such that they could become both at peace in the midst of a battle, and also fully in command of their faculties, with presence and clarity of mind (Cleary 2005). The stance of a warrior most prepared for action was with his abdomen extended and his shoulders unobtrusive (Lock 1980). In his ethnographic study on Aikido practitioners, Dykhuizen (2000) notes how 'speed and power come from the hara' (p. 747).

⁸ Please see Appendix 02 – Shiatsu theory

⁹ The samurai (or bushi) were the warriors of premodern Japan. They later made up the ruling military class that eventually became the highest ranking social caste of the Edo Period (1603-1867). Samurai employed a range of weapons such as bows and arrows, spears and guns, but their main weapon and symbol was the sword.
Source: <http://www.japan-guide.com/e/e2127.html>

Yates (2006) describes the hara as an area from 'above the pubic bone, round the side of the body, defined by the anterior iliac spines to under the rib cage' (p. 216) and Beresford-Cooke (2003) states that developing a strong hara is essential for a Shiatsu practitioner. Once a student has learned to crawl 'naturally' through gradually shifting their body weight on to each limb in turn while allowing the other three limbs to support their body and aided by their hara, they have understood the basic Shiatsu technique (Beresford-Cooke 2003).

However, Kishi and Whieldon (2011) note that although usually translated as the abdominal area, hara has a much broader meaning than is conveyed by a purely anatomical definition which barely scratches the surface of its expression in Japan.

Cultural practices

As discussed above, Shiatsu practice is grounded in Japanese culture. As part of setting the context for this thesis, based on my experiences as a practitioner, I highlight below some cultural practices associated with the social world of Shiatsu.

Shoes off – stepping into the social world of Shiatsu

It is accepted practice to leave one's shoes at the entrance to a room in which a Shiatsu event (for example, training, AGM) is to take place. Removing one's shoes at the entrance to a building is rooted in Japanese culture and is symbolic of respect. In her study of the Japanese home, Daniels (2010) discusses how the Japanese question the European habit of wearing shoes inside the home on the basis that the removal of shoes at the entrance to houses and the various uses of slippers is associated with a concern for cleanliness. Thus, as Shiatsu is grounded in Japanese culture, not to remove one's shoes at the entrance to a Shiatsu venue is tantamount to displaying significant disrespect.

The ritual of removing shoes at the entrance to a venue is not only symbolic of stepping into a different culture but also stepping out of a known social world.

Sitting in a circle

Sitting on the floor in a circle is a common Shiatsu social practice at the start of a Shiatsu gathering (Kishi and Whieldon 2011). Participants in a training session or meeting gather together in this way for discussions at various points, particularly at the beginning and the end of an event as well as during a session. Whole meetings, such as AGMs will be conducted in this way. It is also used for meditation and chanting. Beresford-Cooke (2003) suggests that sitting on the ground encourages a sense of groundedness and flexibility. Sometimes the practice is to stand instead of sit, for example to do exercises such as warm ups or Chi Gung.

Exercises and demonstrating bodywork

Often circle time is followed by some sort of exercise which usually has some bearing on/relation to the Shiatsu physical work that will be taught during the session. For example, the class may perform Makko-ho stretches (yoga-type movements) with a particular emphasis on the meridians being taught that day. This will usually be followed by a demonstration of the particular focus of bodywork by the teacher using the assistant or student as the body. People will then partner-up and practise what they have observed. The session usually ends by returning to the circle for discussion.

Definitions, extent of use and evidence

In this final section, I outline a range of definitions of Shiatsu from the organisations previously mentioned in the review. I then give an indication of the extent of use and finally review the evidence base in relation to Shiatsu.

Defining Shiatsu

The differing classifications of Shiatsu highlight the difficulty of applying Westernised constructs to health practices with very different philosophical and theoretical roots and definitions of Shiatsu tend to vary according to the particular focus of style. The House of Lords Select Committee defines Shiatsu as ‘... a type of massage originating from Japan which aims to stimulate the body’s healing ability by applying light pressure to points across the body ... and which ... relies on the meridian system of ‘qi’ in a similar way to traditional Chinese medicine and acupuncture’ (House of Lords 2000, para. 2.3). The NCCAM classification positions Shiatsu more broadly as a ‘manipulative and body-based practice’ (NCCAM 2014).

The Shiatsu Society (UK) describes Shiatsu as ‘a traditional hands-on Japanese healing art, Shiatsu can help in a wide range of conditions from specific injuries to more general symptoms of poor health. Shiatsu is a deeply relaxing experience and regular sessions help to prevent the build-up of stress in our daily lives’ (Shiatsu Society 2014). The Zen Shiatsu Society (UK) recognises Zen Shiatsu as a mindful approach to contact-healing based on the organ-meridian networks of Oriental Medicine in their physical, energetic and spiritual aspects (Zen Shiatsu Society 2014).

The CNHC offers the following comprehensive description of Shiatsu:

Shiatsu is a touch based therapy that applies pressure to areas of the surface of the body through loose comfortable clothing for the purpose of promoting and maintaining wellbeing. A Shiatsu practitioner will initially consult with the client and plan the Shiatsu treatment. The client will then be positioned comfortably, with appropriate adjustments being made throughout the session. Clear and accurate aftercare advice will be given. Shiatsu is a Japanese word that literally means finger pressure and derives its theoretical and practical roots from the ancient traditions of Oriental medicine. Today it is an autonomous treatment method influenced by Chinese, Japanese and Western knowledge. In addition to being regularly used by thousands of people all over the world, a variety

of charities, health foundations, NHS trusts and hospitals in the United Kingdom provide Shiatsu to support patients whilst receiving treatment for a range of health issues and to help them maintain their general wellbeing. (CNHC 2010)

Thus, as indicated above, Shiatsu purports to promote and support wellbeing, prevent ill health and is a holistic healthcare practice focusing on the whole person – whereby the mind and body are perceived as an energetic whole – in relation to their environment (Long 2008).

Extent of use and provision

According to an omnibus survey carried out by Thomas and Coleman (2004), approximately 0.4% of the population use Shiatsu with a frequency of about eight times per year. It is difficult to be precise about exactly where and how Shiatsu is being provided, but the locations of the practitioners currently registered with the Shiatsu Society (UK) show that distribution is widespread across the UK (Shiatsu Society 2014). Shiatsu is currently used in a variety of healthcare settings including maternity care, addiction units, HIV and AIDS, cancer care, mental health, hospice care, staff care as well as GP surgeries (Connolly 2009).

Evidence

Pirie et al.'s (2012) study suggested that GPs welcomed having more options of care, especially for patients with complex, chronic symptoms, and patients appreciated the increased time and holistic, patient-centred approach during Shiatsu consultations. Pirie et al. (2012) concluded that their study successfully integrated a Shiatsu clinic into a general practice and offers a model for future research on complementary medicine in primary care.

However, Robinson et al. (2011) suggest that the evidence base is limited and apart from one large-scale observational study, the methodological quality of the studies covered in their systematic review was generally poor. Nonetheless, they

suggested that the evidence-base for musculoskeletal and psychological problems is promising and may be a good area to focus future efforts, given the popularity of Shiatsu for these conditions in the UK (Robinson et al. 2011).

The large-scale observational study referred to by Robinson et al. (2011) was commissioned by the European Shiatsu Federation in which the University of Leeds carried out a cross-European, longitudinal cohort study investigating the effects and experience of Shiatsu (Long 2008). Although there were some country variations, a typical user of Shiatsu in Long's (2008) study paid for their own treatment, were mostly woman, aged in their 40s, in paid employment, either full- or part-time, had used Shiatsu before and who described their overall health status as being 'good' or 'better' (p. 921). Based on health outcomes methodology, at 'first-ever' use, the most typical reason for trying Shiatsu was 'out of curiosity' and at subsequent sessions, the dominant reason was health maintenance; the most mentioned symptom groups were problems with 'muscles, joints, or body structure', 'tension/stress' and 'low energy/fatigue' (Long 2008, p. 921). Long (2008) concluded that Shiatsu has a role in maintaining and enhancing health, and may have the potential to make a cost-effective contribution to health care in relation to, for example, tension and stress and musculoskeletal difficulties.

In the context of self-care, as discussed earlier in this review, irrespective of which approach they choose to take, people expect to receive self-help advice as part of a CAM intervention, and this expectation is an important factor in the decision to seek CAM treatment (Richardson 2004). Long (2009) argues that CAM has an important role in supporting individuals to take control of their self-care and examined the potential of Shiatsu in promoting wellbeing and critical health literacy. He suggests that Shiatsu, when pursued on the initiative of the

users – albeit people who may be socially or economically advantaged – may have a potentially powerful contribution to make to population health, particularly when used as part of ongoing support to maintain health (Long 2009).

Concluding comments

In considering the issue of professionalisation, a central question is whether professional groups are motivated predominantly by public interest or self-interest. A neo-Weberian perspective of the professions accounts for the rise of the medical profession and the subsequent marginalisation of healthcare practices not grounded in scientific methods. When orthodox medicine was established in the UK on a formal, national basis in the mid-19th century, the field of CAM came into being as a set of marginalised healthcare practices.

The strategies employed by the medical profession to subordinate other health professions and discredit CAM ensured that the medical profession held a dominant position in UK healthcare provision. From the mid-1960s – as part of a wider societal change characterised by a growing mistrust and questioning of authority – professions, and especially the dominant profession of medicine, were increasingly seen as paternalistic, insufficiently accountable and self-interested. Sociological opinion too started to shift more fundamentally against the ideology that the professions served the public interest.

Against a context of the need for healthcare regulatory reforms in the wake of cases such as the Shipman Inquiry, what is now emerging is a new partnership between the public, professionals, employers and Government with a self-regulatory base which aims to be more cost-effective, involve greater numbers of lay members to represent public interest and meet the contemporary criteria of accountability and transparency. Researchers (see for example, Davies 2004,

Adams 2007a) are calling for a new stream of sociological research to help understand the realities of contemporary healthcare practice.

In the context of CAM practices, there is now support among established CAM researchers for CAM research to embrace different paradigms. Exploring necessary, far reaching questions about the complexity of the field of CAM will broaden and support the search for a clinical evidence base for CAM.

The field of CAM comprises over two hundred diverse healthcare practices and each modality has its own history and characteristics. Therefore, to group all CAM practices under one label is potentially misleading owing to the disparate nature of the varying practices and also that there are often few similarities between practitioners within one practice. Researchers in CAM argue that it is necessary to investigate specific CAM practices through in-depth research to understand the complexities of CAM practice.

Shiatsu is a distinct CAM practice and research evidence shows it has a role in maintaining and enhancing health, and may have the potential to make a cost-effective contribution to health care in relation to, for example, tension and stress and musculoskeletal difficulties. Shiatsu is thus well placed for investigation of CAM practice in the broad context of the sociology of the professions. The outcomes of this research will provide a platform for further research of other types of CAM practices and will be valuable for professional and regulatory bodies, training organisations and commissioners of health care.

Aim of this study and the research questions

As a qualified and practising Shiatsu practitioner, my experience in this respect provides a personal context for undertaking research in this field.

My interest in the field of CAM, and particularly in relation to professionalisation and regulation, influenced my decision to begin my research. The motivation for the specific focus on Shiatsu arose out of a small-scale informal study, as part of the assessment and by way of a project, undertaken in my third and final year of Shiatsu training. The study, which was based on informal conversations and email exchanges, highlighted some important aspects about the experiences of Shiatsu practitioners moving from training into practice. The participants included students, newly qualified practitioners and experienced practitioners. The study provided the stimulus for a more in-depth exploration of how Shiatsu practitioners understand and explain their practice.

This current study seeks to explore the experiences of one group of UK CAM practitioners – Shiatsu – in relation to healthcare provision in the 21st century.

The following research questions are addressed:

- 1) What processes are involved in becoming a Shiatsu practitioner?
- 2) How do Shiatsu practitioners understand and explain their practice?
- 3) What are the opportunities and challenges experienced by Shiatsu practitioners in relation to the professionalisation of Shiatsu?

The next chapter discusses the methodological and theoretical considerations underpinning this study.

CHAPTER 3

Methodological and theoretical considerations

Introduction

This chapter discusses the theoretical and methodological considerations underpinning my research. I first consider ethnography as a methodology, outlining my involvement as a practitioner, and examine reflexivity as a methodological tool. Next I consider narrative inquiry and introduce concepts of social positioning and turning points as methods of inquiry. I then go on to discuss the ethical dimensions, design and analytic strategy of this research. Finally, I consider my reflections on the process and introduce the two data-led chapters.

Part 1 Taking an ethnographic approach

As discussed in the review of the literature, questions about the motivation and background of those who become practitioners, the types of relationships they aim to establish with their patients, how they deal with the day-to-day exigencies of medical practice are best addressed through in-depth research – for example, in the ethnographic tradition (Sharma 1991, Cant and Sharma 1995). The importance of Sharma's research and how her approach influenced my methodological and theoretical considerations, will be discussed further in the final chapter.

Being with people – ethnographically – in their time and space, in all their strangeness and in their 'mundane and quotidian flow' is still one of the most valued ways to build qualitative understanding of the particulars and generalities

of the human condition (Madden 2010, p. 32). It could be argued that as a set of methods, ethnography is not that far removed from the means that we all use in everyday life to make sense of our surroundings, of other people's actions, and perhaps even of what we do ourselves. However, what distinguishes ethnography as a method of research is that it involves a more deliberate systematic approach than is common for most people, one in which data are specifically generated to illuminate research questions and where the process of analysis involves intense reflections including the critical assessment of competing interpretations (Hammersley and Atkinson 2007).

Origins and differing perspectives

The origins of the term 'ethnography' stem from 19th century Western anthropology where ethnography tended to be a descriptive account of a community or culture, usually located outside of the West. Bronislaw Malinowski (1884-1942) is generally acknowledged to have articulated the distinctiveness of ethnography from the more general anthropological project which preceded it. Central to how Malinowski defined the 'new discipline of ethnography' was as a detailed, first-hand, long-term, participant observation fieldwork, written up as a monograph about a particular people, the Trobrianders (Macdonald 2001). From an anthropological perspective, Okely (2012) refers to Malinowski's approach as being close to a 'holistic tradition' (p. 17) in which he 'seriously and soberly' (Malinowski 1922, p. 11) sought to describe every aspect of the phenomena of the Trobrianders.

However, ethnography does not have a universally understood meaning owing to its complex history and has considerable overlap with other labels including, for example, 'qualitative inquiry', 'fieldwork', 'interpretative method' and 'case study' (Madden 2010, O'Reilly 2012). Therefore, ethnography 'escapes ready summary

definitions' (Atkinson et al. 2001, p. 1). Nonetheless, it is widely contended that ethnographic research in particular necessitates interaction, often quite personal and intimate, with research subjects – whether as interviewees or participants in a setting which is being observed (Atkinson and Coffey 2002, Ellis 2004, Denzin and Lincoln 2005, Hammersley and Atkinson 2007, Madden 2010, O'Reilly 2012).

Ethnographic approaches straddle many academic areas. For example, Reed-Danahay (2001) shows there is no clear distinction necessarily between ethnography and studies of life histories. Wilkinson (2011) opens up the possibility of seeing focus group discussions as social contexts for direct observation and, which she argues, will make a study with this particular focus 'necessarily ethnographic' (p. 174). As Barbour (2014) suggests, the term 'ethnographic' can be useful where interviews have been carried out in a setting to which the researcher has had extended access. Thus, in this sense, the ethnographer is immersed in the culture under study and uses both the ethnographic eye and ethnographic ear (Martin 1990) to interpret meaning within the everyday life contexts researched. Some researchers will define their work as ethnographic if it is based on a small number of interviews and some human contact; others will stress the necessity of time and intensity of different forms of contact with great attention to context (O'Reilly 2012). Although Heyl (2001) posits that 'projects based on one-shot interviews would not constitute ethnographic interviewing' (p. 379), Melia (1987) describes her study of the occupational socialisation of nurses, in which she undertook forty one-hour interviews, as 'within the scope of ethnography' (p. 4).

Skeggs (2001) argues that there is 'nothing about ethnography that makes it feminist' (p. 427), yet there is a synergy between feminism and ethnography in

that 'both have experience, participants, definitions, meanings and sometimes subjectivity as a focus and they do not lose sight of context' (p. 426). Potrata (2005) notes there is a shared nature of and affinity between ethnography and CAM and therefore suggests that ethnographic research, with its focus on practice, lends itself to the study of and people's involvement in alternative medicine.

Traditional ethnographic research focused on generating cultural meanings (Silverman 2011) and central to ethnography was the practice of participant observation (Wolcott 1982). Goffman and Lofland (1989) refer to participant observation as:

one way of getting data ... by subjecting yourself, your own body and your own personality, and your own social situation, to the set of contingencies that play upon a set of individuals, so that you can physically and ecologically penetrate their circle of response to their social situation, or their work situation, or their ethnic situation, or whatever. So that you are close to them while they are responding to what life does to them. (p. 125)

To continue in Erving Goffman's words, participant observation involves using your 'tuned-up body' to take the 'same crap they've been taking, to sense what it is they're responding to and *artificially* forcing yourself to be tuned into something that you can then pick up as a witness, not as an interviewer, not as a listener, but as a witness to how they react to what gets done to and around them' (Goffman and Lofland 1989, p. 125). Thus Goffman and Lofland (1989) argue that the rationale for going into the field is about 'getting deep familiarity' (p. 126).

Generating the ethnographic enterprise – reflexivity

In this traditional sense of ethnography, I argue that my Shiatsu practitioner presence enabled me to have an *existing* 'deep familiarity' in the sense that I was already immersed in the field of my research. This is not to suggest that my methodology was autoethnographic which is an approach to 'research and writing

that seeks to describe and systematically analyse (graphy) personal experience (auto) in order to understand cultural experience (ethno)' (Ellis et al. 2011, p. 273). Rather, my intention was to exploit my existing experience and understanding of the field, thus using it to support the research process.

However, my deep familiarity gave rise to an ever-present tension in how I was undertaking research in a field very familiar to me. Classic formulations of ethnographic fieldwork – especially in anthropology – stress the tension between familiarity and strangeness (Becker and Geer 1957a, 1957b, Becker 1961, Geer 1964, Powdermaker 1966). But 'strange' and 'familiar', 'insider' and 'outsider' are no longer easy terms to apply in an increasingly complex world. Different perspectives have challenged the traditional treatment of difference and distance and there is now a fundamental shift away from the fixed positions and dualist nature of subject and object, near and far, familiar and strange, insider and outsider (Atkinson et al. 2003).

Hammersley and Atkinson (2007) suggest, 'once we abandon the idea that the social character of research can be standardised out or avoided by becoming a 'fly on the wall' or a 'full participant', the role of the researcher as an active participant becomes clear' (p. 17). Thus, ethnographic work implies a degree of personal involvement with the field and there can be no disengaged observation of a social scene independent of the observer's presence. Therefore the ethnography is a product of the interaction of the ethnographer and a social world. Furthermore, the researcher and the researched are not unattached and objective instruments, rather research is personal, emotional, sensitive and reflective and situated in existing cultural and structural contexts (Coffey 1999).

As Coffey (1999) argues, in researching the social world, the self is always implicated in the research process. Being a researcher in the field of my practice

– Shiatsu – I am *thoroughly* implicated in the social world of Shiatsu as an active participant. Thus, as highlighted above, in the context of my research, I have sought to use my practitioner-self as a source of knowledge and experience to probe and produce accounts of the social world of Shiatsu practitioners (Coffey 1999).

Nonetheless, a particular ‘danger’ that I faced was ‘the comfortable sense of being at home’ (Hammersley and Atkinson 2007, p. 90). This meant I needed to be mindful that unless I maintained a distance – an analytic space – in all stages of generating my thesis, there was a risk that it would become little more than a personal representation of my fieldnotes and participants’ accounts. Thus, finding a way to suspend my own preconceptions and maintain a marginal, yet meaningful, position was a vital aspect of my methodology.

In her ethnographic study of a hospice, Arber (2006) discusses her ‘dual identity’ as both a practitioner and a researcher and highlights how she used reflexivity as a method for managing the tensions and difficulties around the boundary between closeness and distance in terms of the observer and participant roles. Likewise, the reflexive relationship between the different contexts and aspects of my practitioner-self, my researcher-self and my participants was an important evolving consideration in this study.

Geertz’s (1973) view is that ethnography is not merely a matter of methods – establishing rapport, selecting informants, transcribing texts, taking genealogies, mapping fields, keeping a diary. He ‘defines’ ethnography as a kind of intellectual effort, an ‘elaborate venture’ (Geertz 1973, p. 6) in ‘thick description’, a notion he attributes to Ryle (1971). Hammersley and Atkinson (2007) argue that the very possibility of social life and of understanding it depends on an elementary principle: the interaction between the social actors who are being studied and the

social actor who is making sense of their actions. It is, they suggest, this fundamental principle – reflexivity – which generates the ethnographic enterprise. It is possible the 'intellectual effort' that Geertz (1973) refers to includes the notion of reflexivity as described by Hammersley and Atkinson (2007). However, Atkinson et al. (2003) note that 'reflexivity is a term widely used, with a diverse range of connotations (and sometimes with no meaning at all!)' (p. 147).

Indeed Lynch (2000) recommends a limited notion of reflexivity for the simple reason that it avoids the academic pretensions and fractiousness that can arise from equating reflexivity with a particular intellectual orientation, cultural condition or political perspective. Lynch (2000) sees it not as an epistemological, moral or political virtue but as an unavoidable feature of the way actions are performed, made sense of and incorporated into social settings. In this sense of the word, he argues, it is impossible to be unreflexive (Lynch 2000).

When it began to gain currency in the 1980s, the term 'reflexivity' was often used to refer only to the influence of the personal identity of the ethnographer on the research rather than the wider business (of which attention to the personal was important) of every aspect of the ethnographic enterprise (Macdonald 2001). A limited view of reflexivity, for example, is provided by Tritter (1995) who suggests that reflexivity involves researchers being aware of their own responses and repeating accounts back to respondents to facilitate the construction of a joint account of the phenomenon being researched. In taking such an approach this might suggest a rendering of the whole endeavour into a more technical procedure.

Jordan and Yeomans' (1995) broader view of reflexivity emphasises how it turns the focus on both the researcher and the research act as part of the social world being investigated, and therefore it involves a dialectic between the researcher,

the research process and the research product. May (2002) argues that reflexivity is a study of practices in relation to the positioning of participants. Additionally, reflexivity is more complex than reflection; it involves standing between two mirrors (Cant and Sharma 1998) or looking into a mirror and seeing yourself at the same time as you see others in which the ethnographer is a kind of third person (Harstrup 1987). Pollner and Emerson (2001) refer to reflexivity as what actors 'know about' or 'make of' and 'do in' a setting and how this is 'constitutive of the setting and informed by it' (p. 121). They draw on Garfinkel's (1967) ethnomethodological characterisation of the process of reflexivity '... such practices consist of an endless, ongoing contingent accomplishment ... carried on under the auspices of, and made to happen as events in, the same ordinary affairs that ... they describe' (p. 1).

Hertz (1997) emphasises the ubiquity of reflexivity and how it permeates every aspect of the research process, challenging researchers to be more fully conscious of the research process which is fundamentally about the simultaneous connection and location of people and vocal lives. Etherington (2004) focuses on reflexivity as a skill that researchers develop which is described as an ability to notice responses to the social world and to use that knowledge to inform actions, communications and understanding.

From a feminist perspective, Ramazanoglu and Holland (2002) argue that generally reflexivity involves an attempt to be transparent about power relations within the research process. They suggest that reflexivity involves critical reflection on power relations, accountability as well as ethical and value judgements that might frame the research politically (Ramazanoglu and Holland 2002).

Drawing on these perspectives and my experience, I argue that reflexivity is a particular intellectual orientation involving an endless, ongoing interaction between researcher and the researched and which permeates every aspect of the research process. It involves becoming a foil, allowing the silences to probe sensitively and giving space for emotion. It requires not just the necessary – probably largely instinctive – skills to accomplish this but it is also framed and underpinned by values of honesty, openness, reciprocity. I argue that this kind of reflexivity (which I discuss further below) is central to being a Shiatsu practitioner and which I then transferred to being a researcher. Furthermore, I argue that through exploiting my presence reflexively and applying it fully and systematically as a methodological tool (Hammersley and Atkinson 2007) it becomes a significant productive force (Madden 2010).

Thus, I argue that being a Shiatsu practitioner not only meant that I was immersed in the culture of my study but also, as will be discussed further in this chapter, my particular skills as a practitioner became my ethnographic eyes and ears (Martin 1990) as a researcher. Specifically, drawing on how there are a range of ethnographic approaches as discussed earlier, I argue that the ethnographic ear – particularly in relation to listening to narratives – is a cornerstone of ethnography. Indeed, as Riessman (2008) argues narrative interviewing has more in common with ethnographic practice than mainstream social science interviewing practices. Part 2 now turns to a discussion of narrative inquiry.

Part 2 Narrative inquiry

I draw principally on the work of Catherine Kohler Riessman and Elliot Mishler as key authors in relation to narrative inquiry. Riessman (2008) cautions against what she perceives as the limited and popularised notion of narrative as 'just talk and text' and how this has become the 'tyranny of narrative' (p. 5). She argues that among serious research scholars in the social sciences working with first person accounts, there is a range of definitions of narrative, often linked to an academic discipline or disciplines (Riessman 2008). However, despite the diversity of definitions, one fundamental feature of the concept of narrative is that all narratives work with contingent sequences of events and ideas (Riessman 2008). As Mishler (1999) notes, he 'respecified' his original definition of interviews from that of 'speech events' to 'socially situated actions' to emphasise their location within ongoing streams of social interactions (p. 19).

Riessman (2008) proposes a continuum of narrative definition whereby one end is associated with what she refers to as the 'restricted' (p. 5) practice of social linguistics first proposed by Labov and Waletzky (1967) involving a discrete unit of discourse, an extended response by a participant to a single question. At the other end of the continuum, associated with social history and anthropology, Riessman (2008) suggests that narrative can refer to an entire life story, woven from threads of interviews, observations and documents. Residing in the centre of this continuum of working definitions are the practices of the disciplines of psychology and sociology whereby personal narrative encompasses long sections of talk (Riessman 2008) and which involve lengthy accounts that develop over the course of single or multiple research interviews or therapeutic conversations. A good example of the complex process involved in constructing trajectories of identity formation through extended interviews is Mishler's (1999)

study of craftartists in which he used the thematic concepts of narrative and identity.

Social positioning and identity in narratives

As Mills (1959) notes, individuals' narratives are works of history as much as they are about individuals, the social spaces they inhabit and the societies they live in. Specifically in relation to narrative inquiry, the notions of *social positioning* (Riessman 2001) and *ventriloquation* (Bakhtin 1981) became useful theoretical considerations from which to examine my participants' experiences in respect of Shiatsu. These concepts align with and are part of identity formation, as discussed further below.

Social positioning in narratives refers to the way in which participants choose to position themselves socially in relation to others (for example, other characters within their story as well as their audiences) and gives insight into how they wish to portray themselves in the context of their stories (Riessman 2001). Social positioning, which is often very fluid, serves as a useful point of entry for analysis (Riessman 2001). For example, narrators can position themselves as victims of a particular set of circumstances within their story, giving other characters power or control in that situation (Riessman 2001). Alternatively – within the same story – narrators can portray themselves as 'agentic beings' or individuals who 'purposefully initiate and cause action' (Riessman 2001, p. 702). Narrators shift between positions giving themselves active as well as passive roles in different parts of their stories. Often these 'fluid semantic spaces' are created through the use of particular grammatical constructions and particularly the use of verbs (ibid). Thus, the way that narrators position themselves in their stories signifies their 'identity performance' and in ethnographic studies the performance event has 'assumed a place beside the text as a fundamental unit of description and

analysis' (Mishler 1999, p. 19). As Riessman (2008) argues, performances are expressive and they are performances for others:

... to put it simply, one can't be a 'self' by oneself; rather, identities are constructed in 'shows' that persuade ... (p. 160)

From a social perspective in relation to the concept of communities of practice (discussed in more detail in the final chapter), Wenger (1998) posits that there is a profound connection between identity and practice. He suggests that identity in practice arises out of an interplay of participation and reification – it is a 'constant becoming' and perpetually renegotiated during the course of our lives (Wenger 1998).

There is therefore similarity between Riessman (2008), Mishler (1999) and Wenger's (1998) notions of identity:

We cannot become human by ourselves: hence a reified, physiologically based notion of individuality misses the interconnectedness of identity. (Wenger 1998, p. 146)

In the context of social research, using personal narratives, Mishler (1999) applied a socially distributed notion of identity in his study of craftartists to examine how individuals made identity claims on the basis on their social position by aligning or contrasting themselves with others; how they marked out the boundaries and limits of their relationships with others. Thus, how participants define themselves – who they are – reflects the particulars of their social space and their ways of positioning themselves within it.

Turning points and trajectories in narrative inquiry

Riessman (2001) defines 'turning points' as 'moments when the narrator signifies a radical shift in the expected course of a life' (p. 705). In life course theory, turning points reflect the temporal nature of lives and convey a sense of a

substantial change in direction (Elder Jr et al. 2003). Wenger (1998) argues that identities form trajectories through a succession of forms of participations across and within communities of practice. Thus Wenger (1998) suggests that identity is not only fundamentally temporal and ongoing but also 'defined with respect to the interaction of multiple convergent and divergent trajectories' (p. 154).

Reflecting Wenger's (1998) notions of trajectories, Elder Jr et al. (2003) posit that experiences leading to turning points form 'social pathways' or trajectories involving a sequence of transitional experiences (p. 8). In his study of craftartists' narratives, Mishler (1999) referred to turning points as experiences of 'accidents, unplanned changes and unforeseen events that led to shifts of course and re-specifications of what they were about and who they were' (p. 60). Mishler (1999) found that near the 'sudden-dramatic pole of change people experienced accidents of self-discovery' (p. 62). Thus, turning points are implicit in Wenger's (1998) concepts of identity and trajectories.

Reflecting Riessman's (2001) argument that narrators can position themselves as victims or otherwise, Rutter and Rutter (1993) distinguish between positive turning points and negative turning points. They regard positive turning points as 'major life experiences that alter life circumstances for the better in some way' (Rutter and Rutter 1993, p. 357). Drawing on Elder and Caspi's (1989) notion of the accentuation principle, Rutter and Rutter (1993) suggest that experiences associated with stressful or challenging events mainly accentuate the personal or relationship qualities already present. As such, this kind of experience can be viewed as a 'provoking agent' for emotional distress or psychological disorder and can lead to a negative turning point (Rutter and Rutter 1993, p. 357).

Turning points and agency

As Riessman (2001) notes, narrators can portray themselves as 'agentic beings' and this section gives some consideration of the notion of agency. Hitlin and Elder Jr (2007) suggest that some researchers intuitively recognise the concept of agency as important and concerning choice yet 'it remains a slippery concept' (p. 171). Debates addressing the reciprocity of person and society – agency versus structure – now tend to conclude that it is erroneous to posit a strict dualism between agency and structure (Hitlin and Elder Jr 2007).

To life course analysts, human agency is an individual-led construct which is fundamental for social action (Hitlin and Elder Jr 2007). Elder Jr et al. (2003) refer to the principle of agency as how 'individuals construct their own life course through the choices and actions they take within the opportunities and constraints of history and social circumstance' (p. 11). However, Flaherty (2013) argues that the role of agency in the life course remains paradoxical because the relationship between determinism (arising from the externality and constraint of social structure) and self-determinism (concerning agency) is unresolved.

Lave and Wenger (1991) argue that theorising of practice or praxis requires a broad view of agency which emphasises the integration and interdependence of practice to agent, world, activity, meaning, cognition, learning and knowing. The role of participation and identity is central to the socially negotiated character of meaning between persons and their place and participation in communities of practice.

Thus in Part 1, I have discussed how ethnographic work involves personal engagement with the field. Crucially, I have argued that reflexively exploiting my practitioner-self – my existing familiarity of the field – is an important methodological tool. Furthermore, in the context of the notion of reflexivity as I

have argued earlier, I have suggested that the values and skills involved in being a Shiatsu practitioner can be transferred to being a researcher.

In Part 2, I have argued that narrative interviewing has much in common with ethnographic practice. Critically, the ways in which participants position themselves and signal their turning points in their accounts highlight an important connection between their experiences and the wider spheres of societal influences and structures.

In the next part I discuss the practical and theoretical issues involved in putting the research process into practice.

Part 3 Putting the research process into practice

I begin this part by considering the ethical dimensions of this study. I then discuss how I approached the field, including my recruitment strategy. In the next section I consider my data generation strategy before finally discussing my strategy for data analysis.

Ethical considerations

As Madden (2010) notes, at every phase of ethnographic research there is an 'ethical backdrop' (p. 33). What he highlights is the ongoing nature of ethical considerations captured in McDonach et al.'s (2009) cautionary words against adopting a checklist or template approach to ethical approval in that this attitude may encourage a sense of a 'hurdle' to overcome rather than ethics being a process to be continually revisited (p. 239).

Guillemin and Gillam (2004) highlight two major dimensions of ethics in research:

(i) 'procedural ethics' which usually involves seeking approval from a relevant

ethics committee to undertake research involving humans, and (ii) 'ethics in practice' or the everyday ethical issues that arise in the doing of research.

Procedural ethics

Ethical approval for this study was obtained from The Open University's Human Research Ethics Committee (HREC) and included proposals for data generation to be undertaken according to the following principles:

- respect for the autonomy of the participants
- non-maleficence
- respecting and maintaining confidentiality and anonymity.

Respect for autonomy and informed consent

Prior to agreement to take part in this study, participants were sent a letter of invitation to participate which included sufficient information about the research to enable them to become involved in a way that was free from coercion or undue influence. An information leaflet¹⁰ that described the research project and an 'Agreement to participate'¹¹ form were developed. Following critical review and approval of these documents by HREC, they were given to all eligible individuals expressing an interest in becoming participants. These individuals were assured at the start of the project that they would remain anonymous throughout and during dissemination. Participants were given opportunities to ask questions, seek further information and were free to withdraw at any point if they so wished.

Non-maleficence

Data generation was undertaken in a way that was respectful to the participants (for example, permission was sought to collect publicity leaflets or use comments from forums) and did not cause inconvenience. For example the timing and

¹⁰ Please see Appendix 03 Information leaflet

¹¹ Please see Appendix 04 Agreement to participate

location of interviews were carefully negotiated to ensure that these suited the participants.

Confidentiality and anonymity

All participant details from and in the data remained confidential at all times and were viewed only by my supervisors, myself and one person recruited to transcribe. Pseudonyms were substituted for the names of the participants to ensure they could not be identified and will remain anonymous.

The rights of the participants were considered and protected by continually negotiating consent with each one throughout the different phases of the research process. Data were stored according to the Data Protection Act and Freedom of Information Act.

Ethics in practice

As Coffey (1999) notes, debates and discussions around ethical dimensions of ethnography involve several important issues including: informed consent; the status of privacy; the distinction between what can be made public and what should remain private; harm and exploitation; and risk. Brinkmann (2007) suggests that there is a blurred analytic distinction between ethical and epistemic issues in qualitative research, because a sharp distinction does not reflect the human situation. Furthermore, Brinkmann (2007) argues that ethics and qualitative research are largely concerned with the 'same plane of existence', and the capabilities that make good qualitative researchers are 'at once ethical and epistemic' (p. 16).

In ethnographic research, ethnographers must weigh the importance and contribution of their research against the chances and scale of any harm that is likely to be caused to the people involved, to others, or to future access, against the values of honesty and fairness, against any infringement of privacy involved,

and against any likely consequences for themselves and other researchers (Hammersley and Atkinson 2007). In practice, this means that on the basis of a realistic view of human relations – not an idealised one – there will be conflicting indications, difficult judgements and probably disagreements (Ellis 2004). Both Hewitt (2007) and Guillemin and Gillam (2004) propose that reflexivity is a helpful concept to inform how ethical practice in research can be achieved.

Guillemin and Gillam (2004) suggest that it is within the dimension of ethics in practice that the researcher's ethical competence comes to the fore. What they mean by this is the researcher's willingness to acknowledge the ethical dimension of research practice, his or her ability to actually recognise this ethical dimension when it comes into play, and his or her ability to think through ethical issues and respond appropriately. However, in examining the researcher-researched relationship, Hewitt (2007) argues that official guidelines and ethical codes of practice do not provide adequate support to help the researcher navigate the continually evolving course and context of research in a way that is morally responsive to the participant, while ensuring the integrity of the research. In contrast, Coupal (2005) proposes that a greater emphasis on the ethical principles of individual human dignity, and justice and inclusiveness would provide moral ground for practitioner-researchers.

Although it was my intention, as Mauthner et al. (2002) suggest, to maintain an awareness of the need to apply the guidelines for ethical research practice throughout the ethnographic process, I was aware that 'mobilising my insider capital' (Voloder 2014, p. 1) posed an ethical dimension to entering the field as a researcher. In this respect, I recognised I would be 'obliged to reflect on the nature of my own professionalism' both as a researcher and a practitioner (Cant and Sharma 1998, p. 244).

Drawing on Coupal's (2005) proposed approach, as a researcher I strove to ensure that at every stage of my research I considered the range of possible consequences of actions in relation to ethical considerations. Furthermore, I based my practice on the values and principles of 'feminist prescriptive ethics' (Skeggs 2001, p. 433) whereby I always aimed to treat participants with respect based on reciprocity, honesty, accountability, equality and embracing emotion. These guiding principles underpinned my practice not only as a researcher, but also my practice as a Shiatsu practitioner. Thus, I argue that contrary to Hewitt's (2007) assertion above, my practitioner code of practice supported my practice as a researcher in the context of ethics in practice.

Following ethics approval by The Open University's HREC, I began the process of data generation by first negotiating access and recruiting participants; in the next section I discuss how I began to approach my *practitioner* field as a *researcher*.

Approaching the field

Talking to people is the first, crucial ethnographic task and therefore the opening conversations and communications one has in setting ethnographic research are typically forms of negotiation (Madden 2010). Hammersley and Atkinson (2007) note that gaining access is a thoroughly practical matter in that it draws on the intra- and inter-personal resources and strategies that people tend to develop in dealing with everyday life. As noted above, my presence as a Shiatsu practitioner in the field of my research facilitated ease of access to participants. However, negotiating access is one of the stages in the ethnographic process that involves ethical consideration, particularly with respect to whose permission needs to be obtained.

In the early days when I first began this study, I talked with friends and colleagues in the Shiatsu social world¹² about my ideas and explained where my interest and motivation for my research stemmed from. My conversations took place in and across various contexts and settings, for example, at local Shiatsu practice classes, Shiatsu Society (UK) Annual General Meetings, workshops, Shiatsu Society (UK) Congress¹³. Many people were curious to know more and some offered to become participants. As such, I felt there was already a potential source of participants for my research. Thus, my position as a practitioner in the social world of Shiatsu was a key factor in initiating the process of gaining access to and recruiting participants.

Recruitment strategy

Working on a pragmatic basis – determined largely by time and cost – I aimed to recruit participants who lived within approximately a 50 mile radius of my home to avoid having to travel far. However, in the end I extended this radius quite considerably as I was approached by participants living further away. Based on my research questions, three categories of Shiatsu practitioners informed my recruitment strategy:

1. students of Shiatsu
2. practitioners who had recently graduated
3. experienced Shiatsu practitioners (who worked full- or part-time as practitioners).

Recruiting participants via the eShiatsu News – a serendipitous train journey

The original plan was to recruit approximately 15 participants using snowball sampling which involved making contact with a small group of people who were

¹² Please see Appendix 05 Participants - network of relationships

¹³ Shiatsu Society Congress – an annual event, usually over a period of 3-4 days, hosted by the Shiatsu Society and open to all its members comprising a number of workshops designed to enhance and develop practice.

relevant to my research (Bryman 2004). Using my Shiatsu practice class¹⁴ in this respect, I proposed to establish contacts with potential participants. However, following a serendipitous conversation with the Shiatsu Society administrator on the journey back from a Shiatsu event in London, it began quite unexpectedly in a different way¹⁵. She asked about my research and, just as others I had spoken with about my research, appeared genuinely interested. After reading one of my leaflets she offered to post a note to the Shiatsu Society eNews suggesting that anyone who would like to participate in my research should get in touch with me. In a sense, by the administrator offering to do this, I felt as if my research had been given an informal endorsement by the Shiatsu Society. Feldman et al. (2003) argue that what motivates gatekeepers to agree to access is a key aspect of the access process. Although it was not clear to me what motivated the Shiatsu Society administrator to offer to help, the work of Feldman et al. (2003) may be relevant in that they suggest people may help researchers because they genuinely like the researcher and want her or him to succeed or wish to further knowledge in a way that study of the entity, to which they grant access, can provide.

Six practitioners contacted me following the note that was subsequently disseminated by the Shiatsu Society eNews. I had had some prior contact with three of these people in the Shiatsu social world. I sent Information Leaflets and Agreement to Participate forms to everyone, two of whom did not respond further. Four participants (Ellen, Rita, Maggie and Madelaine) were subsequently recruited to the study in this way.

¹⁴ This class is run by Lavinia on a monthly basis at a local village hall

¹⁵ Please see Appendix 06 The inaugural meeting Campaign for Shiatsu

Recruiting participants via the local practice class

The Shiatsu practice class was where I met with, on average, six to eight other Shiatsu practitioners about once a month. As such this class provided a context and setting for participant observation. Lavinia was also the practitioner to whom I go for Shiatsu treatment. She was one of the main people to whom I had spoken about my research and she was very willing for me to talk about my research at the practice class. Lavinia offered to contact everyone and ask if they would be happy for me to talk about my research and take notes at the next practice class. She agreed to send my Information Leaflets and Agreement to Participate form and (as gatekeeper) did not think that anyone would object.

Three participants (Sally, Stephanie and Leo) were recruited this way, although I knew all of these people in other contexts (having met them at other Shiatsu events such as AGM for example). Lavinia also agreed to become a participant.

Recruiting participants via Lavinia emailing her students

This method of recruiting participants, of whom I had had no prior contact, proved to be the most successful in terms of recruiting the most participants. In the same way that I felt the Shiatsu Society administrator gave my research credibility, Lavinia emailing her students suggesting they contact me afforded a similar endorsement. Seven participants (Joan, Kat, Anita, Sheila, Doris, Rona and Megan) were recruited in this way.

Recruiting participants via my direct approach

My strategy for approaching practitioners directly was two-fold: first, to recruit people with whom I had no direct prior connection and who were experienced Shiatsu practitioners (the third category in the recruitment strategy). Second, having already interviewed several participants by this point, I had heard of Natasha, knew of her work and seen her events but had never actually spoken to

her. I emailed her directly and she readily agreed to become a participant.

Another serendipitous meeting (at one of Leo's residential post-graduate training weekends) led to the recruitment of Olivia.

Recruiting participants via participants approaching me

Two people got in touch directly with me having heard about my research via the Shiatsu Society eNews. I had not had any prior contact with either of these people. After sending the preliminary information to both people, one person didn't respond (this person had approached me by email) whereas the other person (Nora) who had contacted me by phone, was recruited.

Eighteen participants were recruited in total. The names and number of participants, recruited to each of the three categories mentioned earlier, are given in Table 2 below.

Table 2 Participants recruited¹⁶

Recruitment category	Names of participants	Number of participants
Students of Shiatsu	Nora, Anita, Rona, Megan, Sheila, Doris, Kat	7
Practitioners who had recently graduated	Joan, Stephanie, Ellen, Rita	4
Experienced Shiatsu practitioners (who worked full- or part-time as practitioners)	Maggie, Olivia, Sally, Natasha, Madelaine, Lavinia, Leo	7

Data generating strategy

I use the term data 'generation' as opposed to 'collection' to emphasise the active role played by me as the researcher in producing data through interacting with

¹⁶ Please see Appendix 05 Participants – network of relationships and Appendix 08 Summary of participants' characteristics

my participants (Barbour 2014). The data generating strategy included three primary sources:

- Narrative interviews with participants
- observation of participants' actions and accounts in the field
- documentary evidence.

I outline briefly each of these strategies below.

Narrative interviews with participants

Interviewing is a cornerstone ethnographic method (Madden 2010). Heyl (2001) argues that a researcher undertaking ethnographic interviewing should aim to 'listen well and respectfully', develop a 'self-awareness of our role in the co-construction of meaning', to be 'cognisant' of the broader social context and 'recognise that dialogue is discovery and only partial knowledge' will be generated (p. 370). Denzin and Lincoln (2005) suggest that managing the dynamic interplay between story teller (participant) and researcher in order to facilitate the co-construction of knowledge requires highly tuned sensitivity, and well-honed facilitative and intuitive skills, and Spradley (1979) highlights the importance of developing sufficient trust in this respect to allow a harmonious relationship between ethnographer and participant so that information can flow freely between them.

In addition, Mishler (1986) foregrounds the issue of power in the process of interviewing and posits there is a close link between the effort to empower participants and the way they organise their responses as narratives. An interviewee-interviewer relationship designed to empower, will encourage participants to 'speak in their own voices' and 'tell their own stories' (Mishler 1986, p. 118).

A 'grand tour question' – the interviewer-traveller

My approach was to ask the same open-ended question initially of all my participants and give them free range to hold a dialogue with me (Okely 2012). In this respect I adopted Spradley's (1979) method of using 'grand tour questions' which are essentially questions which ask participants to describe situations that were inaccessible to the researcher. In effect, these questions were designed to simulate an experience many ethnographers might have had when they first began to study a cultural scene. For example, Spradley (1979) could not ask tramps to give him a grand tour of the Seattle City Jail so instead he asked a 'grand tour question': 'Could you describe the inside of the jail for me?' (p. 50). In this way Spradley (1979) was able to generate a large sample of cultural terms. Although I was familiar with the field of Shiatsu, I adopted this technique by asking all participants 'Tell me what drew you to Shiatsu?' to invite them to begin to tell their story which I could contrast not only with my own but with that of other participants. Furthermore, I drew on Kvale's (2007) metaphor of interviewer as traveller in how the 'interviewer-traveller' wanders through the landscape and enters into 'conversations with the people he or she encounters' (p. 19). In this way the interview – or more appropriately a conversation – became a journey in which participants were invited to tell their own stories in their own ways and voices (Mishler 1986).

Talking with participants

As indicated in the appendix 'Summary of participants' characteristics (Appendix 08), of the eighteen participants who feature in this research, interviews were held on a one-to-one basis with one exception, where at their request, two participants (Doris and Megan) were interviewed jointly. This happened because Megan arrived with Doris and they asked if Megan could join in; not only had I no objection but was very pleased to welcome another participant!

All interviews took place at a mutually agreed time and venue. Three of the interviews took place by telephone. Two participants were interviewed (on a one-to-one basis) twice (see below), otherwise all participants were interviewed just once. I held informal conversations in other contexts with many participants and made a record of these conversations in my fieldnotes. Our conversations were recorded using a digital recorder and all data were stored in accordance with Data Protection and Freedom of Information Acts and equal opportunities legislation.

In defence of 'one-shot' interviews – a story to tell

Despite successfully recruiting participants across a range of ages and experience, I had some concerns about the possible limitations of what Charmaz (2002) refers to as 'one-shot' or single interviews. Charmaz (2002) is sceptical about 'one-shot' interviews as interviewers miss opportunities to correct earlier errors and omissions and construct a denser, more complex analysis. She suggests that a one-shot interview may capture a participant's views and preferred self-presentation at one point in time and both of these can change. Consequently, Charmaz (2002) argues that the 'contribution of the research to a theoretical rendering of the empirical phenomenon has less power' (p. 682). Although Charmaz (2002) also argues that conducting multiple interviews fosters trust between interviewer and interviewee, which allows the interviewer to get closer to the studied phenomenon, as discussed previously I argue that in my practice as a Shiatsu practitioner, developing trust is essential in respect of an effective practitioner-client relationship and I applied these skills to my relationship with my participants. For example, allowing people to speak and not interrupting and keeping eye contact are all important aspects of developing a good rapport (Spradley 1979).

Nonetheless, I was concerned to ensure that my data-generation strategy should be as thorough as possible. Thus, when two participants seemed very keen to hold another conversation with me, I agreed to interview them each again within a relatively short space of time. On each occasion, although we more or less resumed the conversation from where we had left off, I noticed – despite my probing and nudging – they seemed to want to talk about the same experiences over again. It was as if they had a story to tell and they were going to tell it! As such, I felt that interviewing individual participants a second time might not necessarily generate further data. Furthermore, I felt that if it was not possible to carry out the second interview within a relatively short space of time, it could potentially undermine or distort my strategy of creating a landscape of practice from across a range of participants at a particular time in their lives. I decided therefore, to interview participants once.

Observation of participants' actions and accounts in the field

As discussed above, participant observation – one of the core activities in ethnography – involves establishing a place in some natural setting on a relatively long-term basis in order to investigate, experience and represent the social life and social processes that occur in that setting (Emerson et al. 1995). My starting point for observing participants' actions and accounts was my prior knowledge of and presence in the field which facilitated access to the following contexts:

1. Six practice classes – along with six to eight Shiatsu practitioners, I attend a local monthly Shiatsu practice class.
2. An Extraordinary General Meeting (EGM) of the Shiatsu society – this meeting was convened as an EGM and was '... run using the approach called Open Space which was designed to empower the membership of

an organisation and to listen and act on the issues that people really care about' (eNews, 3 June, 2011).

3. Two Shiatsu taster sessions – these sessions are ad hoc events usually organised by a group of practitioners often as part of another event – for example, a wider CAM festival. Practitioners provide short (usually around 15 or 20 minutes) 'taster' sessions of Shiatsu for individuals.
4. Three 3-day residential post-graduate Continuing Professional Development (CPD) events – organised and led by one of my participants.

Documentary evidence

Several sources of documentary evidence have been collected and used in the process of analysis of the broader cultural and social context. These included:

1. My fieldnotes which document observations including my reflections upon these observations
2. Textual data associated with the Shiatsu Society:
 - eNews (twice-monthly bulletin sent to members via email)
 - Shiatsu Society Journal (quarterly, printed and sent to members by post)
 - various documents (Shiatsu Society meeting notes, publicity leaflets, hand-outs from workshops/practice classes)
3. Shiatsu Society (UK) website forum discussions – where Shiatsu practitioners post their reflections, queries and points for discussion.

Data analysis strategy

Analysis of data is not a distinct stage of the research (Hammersley and Atkinson 2007) and is 'significantly open-ended in character ... a creative act' (Lofland and Lofland 1995, p. 181). The process of analysis began informally in the pre-fieldwork phase, originating from my interest in Shiatsu, and my embodied

hunches and ideas led to the subsequent formulation of my research questions, design and data generation. Although as Madden (2010) notes, the formal process of analysis begins with analytic notes and memoranda, it is nonetheless essentially iterative, requiring a flexible and adaptable approach. As such, my strategy for data analysis involved an approach in which I used my ideas to make sense of data interchangeably with using the data to change my ideas (Hammersley and Atkinson 2007).

Thus, I was 'thinking' (Robson 2002, p. 487) about my data on an ongoing basis which involved noting down in the form of memoranda and fieldnotes, and indeed any thoughts that occurred to me.

Looking for recurrent themes, challenges or discrepancies

Drawing on ethnographic data analytic approaches as discussed by, for example, Miles and Huberman (1994), LeCompte and Schensul (1999), Brewer (2002), Lofland et al. (2006) and using my existing ideas and those of the literature, I examined my fieldnotes, transcriptions (of digitally recorded conversations) and other textual data to look for patterns – perhaps routine activities, rituals – and anything that might stand out as surprising or puzzling, for example, unusual participants' terms, exceptions, inconsistencies. I also searched for any apparent inconsistencies or contradictions among the views of different and same individuals. Additionally I reflexively examined the data for how it might have related to what I might have expected on the basis of common sense knowledge, my existing familiarity with the field, previous theory. I also searched for illuminating parallels, more theorised accounts or findings from other studies that might give analytic purchase. My analytic strategy reflected a case-centred comparative approach (Riessman 2008), guided by my research questions.

Generating a landscape of practice

As indicated above, the participants involved in my study spanned a range of ages from early 20s to around 60 years of age. Some participants chose to begin their stories at a point when they were very young. With the younger participants this relates to a recent period but in older participants this refers to as long ago as the 1960s. As such, this range provided a temporal dimension, not only in age but also in relation to where my participants were in relation to practising Shiatsu.

In this sense – although I did not think of it in this way at the beginning – I had generated a 'landscape' of practices (Wenger 1998, Wenger-Trayner et al. 2015) from the spectrum of participants' life experiences in relation to Shiatsu practice. This gave me a sense that Wenger's (1998) theory of communities of practice might be a useful theoretical perspective from which to consider my data and which is discussed in the final chapter.

Analytic framework

Juxtaposing the methodological considerations in relation to narrative inquiry (including trajectories, turning points and social positioning) and Etienne Wenger-Trayner's theories of landscapes of practice (which will be discussed in the final chapter) provided a set of 'interpretive resources' (Mishler 1999, p. 16) not only to gain some analytic purchase on my data but also as a framework for discussion.

The four key components and summary descriptors of my framework comprised:

Trajectories – form a 'continuous motion in relation to a field of influences which connect with the past, the present and the future' (Wenger 1998, p. 154)

Turning points – are 'moments when the narrator signifies a radical shift in the expected course of a life' (Riessman 2001, p. 705)

Social positioning – refers to the ‘way in which participants choose to position themselves socially in relation to others’ and provides a ‘useful point of entry’ for analysis (Riessman 2001, p. 701)

Landscapes of practice – refers to a ‘body of knowledge’ best understood as a complex system of communities’ including the boundaries between them (Wenger-Trayner et al. 2015, p. 13).

Thus, the two data-led chapters form an overall trajectory revealing turning points in participants’ pathways to practice, and ways in which they positioned themselves in these pathways are depicted in an overall landscape of practice. These two chapters encompass the starting points in participants’ journeys, how the student participants envisaged their practice and how qualified participants explained their practice. Participants’ experiences highlight various turning points which sometimes signalled a significant change in direction. Often participants used others’ voices to position themselves in their stories and their voices show how these people often influenced participants’ course(s) of direction.

Part 4 Methodological reflections

In this final part, I reflect on the process of generating the data.

Body-talk

I began to notice when I started my fieldwork (observing and conversing with my participants) that I was drawing on my skills of communication, observation, analysis and recording that I use in my practice as a Shiatsu practitioner. I illustrate this as follows.

At the beginning of a Shiatsu treatment and at the point where a client enters the room, I often begin by asking how they are. As we begin to converse I also begin

to look for clues that will give me information about their health. For example, I observe their posture, gait and the way they move, tone of voice, skin hue and 'look' in their eyes. Such observations or listening to 'body-talk' (Gale 2011) form the basis of Traditional Chinese diagnosis and may all contribute in some way to an overall pattern in which to make sense of their health. When I first started to practise Shiatsu, I tended to write down what clients said and also record my observations in the presence of my client and as they occurred. Being inexperienced, I wanted to ensure that I had as full a record as possible. However, I began to notice when we paused to give me time to write something down, that my note-taking interrupted the flow. Most importantly, I felt, we lost eye contact. In the context of research interviewing, Mishler (1986) suggests that if respondents are not interrupted, they are more likely to tell their stories more fluidly. Eventually, as I grew in confidence, I began to trust my memory and write my notes immediately after the client had gone at the end of the treatment. I began to devise ways of remembering what people had said or what I had observed. I began to develop the technique of scribbling words without looking (sometimes unintelligibly!) and realised that it was very important to write my notes as soon as possible after the treatment otherwise they were easily forgotten.

In the context of my research, I applied this strategy when writing fieldnotes, which is also suggested by other commentators (Emerson et al. 1995). Furthermore, I found that an effective method of recalling¹⁷ what happened was going over or repeating in my mind the 'physical labour, bodily interaction, sensory learning and transformations' as part of the inscriptive process (Okely 2012, p. 107). As such, the way in which I write my notes as a practitioner, as a 'mnemonic device' (Okely 2007), is also applicable in the context of research.

¹⁷ Please see Appendix 07 Reflection: taking notes as a practitioner

Thus, I used my practitioner experience of developing a 'receptive unconscious' and its connection to the building of trust and rapport (Bondi 2014) and applied this to my practice as a researcher.

Forgetfulness of self

Bourdieu (1996) suggests that interviewing can be considered a 'sort of spiritual exercise that aims to obtain, through forgetfulness of self, a true transformation of the view we take of others in the ordinary circumstances of life' (p. 24). I found that the particular phrase 'through forgetfulness of self' resonated with my practice as a Shiatsu practitioner. When doing a Shiatsu treatment, my approach is to practise the basic principle of 'spontaneity and naturalness' in Zen Shiatsu, (Beresford-Cooke 2003, p. 23) and thus my focus is to be unintentionally present therefore maintaining my practitioner self in the background. In this way I aim 'unintentionally to apply good Shiatsu pressure' (Masunaga and Ohashi 1977, p. 55) thus allowing space for my Shiatsu clients to work with me. In the context of my research, I applied the practice of being 'unintentionally present' when speaking with my participants, which I felt not only facilitated the creation of a relaxed atmosphere and mutual trust but also generated free-flowing narrative and intellectual honesty (Okely 2012). Furthermore, although requiring quite a complex awareness on my part, I felt it helped me suspend my own beliefs and preconceptions of Shiatsu practice.

Continuing to 'listen'

The world, in a narrative ethnography, is represented as perceived by a 'situated narrator' which does not focus on the ethnographer herself, but rather on the process of the ethnographic dialogue or encounter (Tedlock 1991). I not only listened to participants' stories during the interview but also continued to 'listen' (Forsey 2010) as I began to analyse the transcripts using my experience and

knowledge as a foil and also being mindful to note when the data challenged my own assumptions or contrasted with my experience.

The analysis of my data was a highly reflexive, iterative process which gradually evolved as I moved back and forth between my ideas, the ideas of others and my data. However, as discussed earlier, although there are no longer fixed, dualist positions in relation to social interactions, there remained the real possibility that during my observations of and encounters with participants and sources of data, in analysing the data and writing my account, my existing knowledge and preconceived understanding might have been an obstacle which meant that I might – albeit inadvertently – have glossed over the mundane or have been blind to the obvious (Atkinson et al. 2003). Additionally, I needed to be sure that I prevented my voice from being too much to the fore.

However, as I worked with my data, I began to realise that although my fieldnotes, other documentary data together with my reflections were important sources of data and ideas, the richest source of contrasts and illuminating parallels were participants' accounts. Their speech acts or their performances enabled me to consider more clearly not just 'What?' my participants spoke about but also 'How?' they spoke about their experiences in relation to 'Who?' they spoke about and to 'Whom?', 'When?' and 'Why?'. This reflects the processes involved in Holstein and Gubrium's (1995) notion of the active interview. I could now begin to understand more about what was going on in their lives that could be subsequently worked into an analytic story. As such these presented the compelling data by which I could gain most analytic purchase.

'Ventriloquation'

As I examined participants' stories I noticed they often cited others – perhaps relations or friends – as important influences in setting them on a path or taking a

certain direction. Furthermore, participants often used other voices to tell their story. This 'multivoicedness' (Wertsch 1991, p. 59) is what Bakhtin (1981) termed 'ventriloquation' (as cited in Holquist's (1981) translation of Bakhtin's work) and is the process whereby one voice speaks through another voice or voice type in a social language. As such, ventriloquating helps narrators to position themselves socially in varying ways within a story (Samuelson 2009). Ventriloquating is dialogical 'expressive equipment' (Goffman 1959, p. 32) used intentionally or otherwise by a narrator during the performance of telling their story.

Relatedly, Bakhtin (1981) refers to the term 'appropriation' when someone appropriates a word, adapting it to their own semantic and expressive intention. Prior to that moment of appropriation the word existed in 'other people's mouths, in other people's concrete contexts, serving other people's intentions' (Bakhtin 1981). Wertsch (1991) suggests it is as if it is 'half someone else's' and not totally their own decision and only becomes 'one's own when the speaker populates it with his own intention' (p. 59).

During my conversations, although the focus was on each participant as an individual, inevitably their experiences involved and related to other people as well as social structures. Sometimes they presented themselves as students (for example, at university, on retreats) or patients, parents, daughters constituting a vast array of complex interactions and relationships. Examples of people mentioned include friends, relations, doctors, clients, housemates as well as CAM practitioners.

Our conversations

In the context of interviewing, Bourdieu (1996) argues that reducing the social and cultural distance through having familiarity with the subject helps to avoid the naïve questions and facilitates the process of understanding. In the context of my

research, I argue that my practitioner knowledge meant that participants did not need to break off their story to explain specific theoretical concepts relating to Shiatsu. For example, if one of my participants mentioned 'Five Element Theory', to have spent time explaining this concept to a researcher who knew nothing about this might have seemed more like a test of the participant's knowledge and which would have detracted from the more important purpose of our conversation, that of talking about their experiences.

Although there were no obvious outward signs, there may have been some unexpressed slight nervousness about speaking into a digital recorder. However, I felt that our conversations started at the point of participation whereby they 'accepted and recognised' (Spradley 1979, p. 48) my role as researcher. I had a slight concern whether their willingness to participate might mean their motivation stemmed from seeing this as an opportunity to convey Shiatsu in a positive light which would mean it was more difficult to probe sufficiently. However, I was also mindful that where my participants might not wish to elaborate on something, I felt it was important to respect this and that it was not my right to stir or disturb beyond this point. However, this juncture – whether to probe or not – had potential ethical tensions as by not probing further, someone (not necessarily the participant) might potentially be placed at risk (Brinkmann 2007). These are complex ethical dilemmas that are not only matters for consideration for practitioners but also for researchers and I was aware as both researcher and practitioner that I needed to be morally sensitive, able to identify ethical issues and respond with moral reasoning to decide on appropriate actions when moral dilemmas occurred (Aita and Richer 2005).

Notes on writing

The ethnographer's interpretation of the phenomenon is always something that is crafted through an ethnographic imagination (Atkinson 2006, p. 402).

In representing participants' accounts I did not want to lose individual participants' voices – how they expressed their feelings, values and emotions – from the overall representation. In representing their stories, I wanted to keep what they actually said as intact as possible. However, a vital stage in the analysis was to ensure that the representations became more than straightforward, simple descriptions of individual participants' stories.

I have drawn on the principles Glesne (1997) used in representing her participants' words. Glesne (1997) describes 'the creation of poem-like compositions from the words of interviewees' as 'poetic transcription' (p. 202).

What this involves is 'the transformation of interview transcripts already produced by a transcriber into poetry' (p. 205). As such, in this sense it is a form of analysis and research writing. The rules of the transformation of transcriptions into poems Glesne (1997) adopted were that the words must be those of the interviewee but that phrases could be taken from anywhere in the transcript and juxtaposed while keeping 'enough of her words together to re-present her speaking rhythm, her way of saying things'. Moreover, this creative transformation was preceded by the kind of coding of the data and identification of themes that is common in much qualitative research. Glesne's (1997) aim was to identify 'the essence of what she was saying' and then to present it in poetic form, but also 'to convey the emotions that the interviews evoked in the researcher'. Glesne (1997) posits that 'poetic transcription creates a third voice that is neither the interviewee's nor the researcher's but is a combination of both' (p. 215).

Thus, I have retained the participants' voices by remaining very close to their words in the representation. Short quotes – bounded by quotation marks – are incorporated within paragraphs. Longer quotes – indented in italics – are represented exactly as spoken, including hesitant pauses and utterances such as 'er' or 'um' and repetitions.

Where participants have made reference to Shiatsu terms, I have used footnotes and appendices to explain and give further detail about Shiatsu theory and practice and drawn on published texts for this purpose.

Concluding comments

I have argued that in the context of taking an ethnographic approach, my reflexivity in respect of my practitioner knowledge of and familiarity with the field provided a methodological tool for this research.

My reflexivity – as discussed above – is an important methodological tool in this respect. However, I argue that some of the practices I have developed as a Shiatsu practitioner are also transferable to being a researcher. Thus, not only was there a constant interplay between my practitioner and researcher self but also between myself as practitioner-researcher-participant. It was never possible to completely separate – I could not just switch off being a practitioner when doing research, but my effort needed to go into ensuring that it was not my voice that came to the fore in all stages of generating this thesis.

Thus, although I do not feature in the construction of the representation I was a constant presence in the process, using my practitioner knowledge and experience of the field as a foil in the production of the ethnography. I include my reflective notes to enable the reader to identify the consciousness which has

selected and shaped the experiences within the representation. Further reflections are included in the final chapter.

The first data-led chapter focuses on 'Getting into Shiatsu' and explores participants' responses in relation to experiences that drew them to Shiatsu and motivated them to seek a qualification. It concludes by examining students' experiences during training and considers the challenges in this respect.

The second data-led chapter focuses on 'Getting out there to practise Shiatsu' and begins with students imagined trajectories into practice. It then considers ways in which qualified practitioners explained how they positioned their practice in the broader healthcare arena, highlighting key tensions in this respect. The chapter concludes by examining the ways in which participants perceived their Shiatsu practice, exposing a potential tension between the theory and practice of Shiatsu.

CHAPTER 4

Getting into Shiatsu

Storytelling, to put the argument simply, is what we do when we describe research and clinical materials, and what informants do with us when they convey the details and courses of their experiences ... (Riessman 2001, p. 696)

Introduction

The data-led chapters collectively form a trajectory toward being in Shiatsu practice. This chapter, entitled 'Getting into Shiatsu', constitutes the start of that trajectory. Inevitably, not only did participants' starting points vary in response to my 'grand tour' question – 'Please tell me about what drew you to Shiatsu?' – but also the extent to which they responded to this initial question. As such there were as many distinct stories as participants¹⁸.

Many participants gave detailed accounts of particular major life experiences which sometimes resulted in significant disruption to their life. There was some judgement on my part in deciding what constituted a major experience. Their experiences often highlighted turning points in which they signalled a change of direction in their life and I drew on these as key indicators of major life experiences. Major life experiences were not always the starting points in participants' stories and often there would be a series of less major experiences nested within the major life experience. I noticed that many participants included other people in their stories, for example friends or family, and often used these people's voices instrumentally to justify their decision to take a particular course of action.

¹⁸ Please see Appendix 08 Summary of participants' characteristics

As indicated in the preceding chapter, I drew on the 'how', 'what' 'to whom' 'when' and 'why' of their experiences to produce the analytic story. Analysis of participants' experiences in relation to my first question suggested five key themes relating to participants' experience of getting into Shiatsu: 'Voyage of self-discovery', 'Supporting my health', 'Supporting the health of others', 'Seeking Shiatsu as a qualification' and 'Shiatsu training as a vast toolbox'.

There is potential overlap between these themes; they are not altogether distinct in that participants did not necessarily fall neatly into one or the other theme. For some participants one of these themes sometimes appeared to be a more significant motivating force than another. The way I have positioned people's experiences does not always reflect the temporal ordering of their accounts.

This chapter is in five parts to reflect the five key themes which highlight a trajectory and set of turning points through which some participants moved, highlighting a range of positions from exploratory experiences (involving a focus on themselves) to a position whereby they sought a qualification in Shiatsu (involving a more outward focus on others). Not all participants necessarily moved through the whole range of experiences.

Part 1 Voyage of self-discovery

For some participants, their motivation for seeking Shiatsu was about self-development. For example, as a young person in her early twenties, Doris became interested in 'complementary therapies from a taster day thing' at the college where she was studying her 'A' levels. What she 'really liked about Shiatsu' was its 'strong focus on self-development' and how this was the 'biggest draw' for her. She was keen to emphasise how she did not perceive this to be a 'selfish thing'; it was not just about developing herself but also to 'help the client

help themselves'. Similarly, Nora's interest in Shiatsu was associated with her interest in spirituality and, like others, she perceived Shiatsu as being 'very linked to a spiritual practice and to somebody exploring themselves and delving into their own experiences'.

Other participants described early life experiences which had had a formative influence in some way. For example, when Leo left school 'really early' aged 15 with an 'A' level in Art, in the late-1960s, he felt he 'was sort of on the Arts side' but 'even further back' he was 'thinking he would cure cancer and had wanted to be a doctor'.

However, after leaving school, Leo became a 'hippie for a year and a half and then decided to go to Art College'. During this time, he lived with some friends, one of whom was the 'white witch of the village who did herbs for anyone who had a physical illness and astrology for anyone with a psychological problem'. The white witch, Eleanor¹⁹, took Leo 'under her wing as an apprentice' and within a year was 'handing people on' to Leo for 'astrological readings'.

Towards the end of this period Eleanor's son, who was a post-graduate mathematician, 'inspired' Leo with maths and music such that Leo decided to 'drop the Art College' and study 'A' levels in maths and chemistry:

I spent about six hours a day doing music, six hours a day doing maths and chemistry and um six hours a day doing witchery [laugh] and those threads ... those three threads have carried on through my whole life you know it's like the therapy, the science and the music. [Leo]

Leo felt that his year with Eleanor and her family was 'the key year' because of these experiences.

¹⁹ pseudonym

Exploring food – frying wood lice and making earthworm

omelettes

Some participants' explorations included ideas around food. For example, when Sally began to get 'this dreadful cystitis' which was stopping her in her tracks because it was 'so painful', she associated this experience with her diet. The kind of food she was eating was 'the usual sort of thing' she had been brought up on, for example, 'white sliced bread, lots of cake and masses of cups of tea'. Sally began 'looking for a whole alternative way of looking at things not just one little thing' and became very interested in food and what to eat. She described this exploration as 'the first inkling that she could do something for herself' and started to think about being a vegetarian and seeking whole foods. She 'gathered this family' around her of 'wholefooders' and had this 'sort of little let it all hang loose kind of period'.

Lavinia's intrigue with and exploration of food began when she was at university studying for a degree in languages and which led her to encounter Shiatsu for the first time. On the advice of a local vegetable shopkeeper, she located an 'East-West Centre' which 'did dietary advice as well as all kinds of things':

so I went along ... they did Tai Chi classes and they were also doing workshops, weekend workshops, in something called Shiatsu which I'd never heard of at that stage and um I booked in for one. [Lavinia]

While he was at university during the early 1970s studying for his first degree in maths and philosophy, Leo was living a house with a 'guy called 'Rick'²⁰ and they felt they were 'practical philosophers in some way' in that they felt the world was 'prescribed' and they 'wanted to experiment with it':

we went through lots of different areas of experience and um like food ... the prejudices we have about food in this culture and ... so we spent

²⁰ pseudonym

*some time frying um wood lice and making earthworm omelettes [laugh].
[Leo]*

Leo and Rick's explorations of food led them to explore Rick's 'fear of falling' and they decided to go and do 'something that involved falling' by joining an Aikido class. The class they attended was run by a 'Japanese guy' who used to do 'Shiatsu' with them when they got injured. Leo 'really felt the good effect of it' and along with another student, asked the 'Japanese guy if he'd teach them what he was doing':

so whenever he did Shiatsu he used to call us over ... it was very very simple Namikoshi²¹ type um Shiatsu ... it was just a few points but his quality of touch was absolutely fantastic and ... what he was teaching was quality of touch and how it related to Aikido. [Leo]

Leo 'basically did this for about six years' and he felt it was 'like absorbing it'. He 'didn't think of it as a career at all'; it was to just do something experiential, 'just part of Aikido training'.

Reading books, seeing pictures

In contrast to the physical experiences as discussed above, several participants talked about books or pictures they had been given or they had found and which had made an impression on them.

For example, Joan had been interested in Shiatsu for many years and although she had not had the opportunity to pursue it she felt that 'even reading about Shiatsu, just felt like it was the place she wanted to be'. It was particularly the 'mindfulness part of Shiatsu' that she found 'peaceful':

²¹ Tokujiro Namikoshi, who founded the Clinic of Pressure Therapy in Japan in 1925, endeavoured to place Shiatsu techniques within a Western scientific framework, characterising points by their anatomical locations rather than the meridian system and favoured a Western scientific approach to treatment over classical theory (Beresford-Cooke 2003). Namikoshi style applies pressure to specific reflex points which relate to the central and autonomic nervous system (Jarmey and Mojay 1999).

this may sound very strange but it felt good, it made me feel good and I liked what they did ... it was entrenched in TCM²² and that seemed logical the way they viewed things so it's the philosophy of it as well as the practical side of it and being present and in the moment when you're doing the treatment. I find it extremely enlightening. [Joan]

When Lavinia 'was about six' an aunt had given her a book on 'Japanese myths and legends' which 'was very precious' to Lavinia. She had been 'fascinated by the difference in culture and the difference in approach to how they viewed life'. Similarly, Kat's mum had given her a book 'with loads of different therapies in' and suggested to Kat that Shiatsu would be 'a good one for her'. Another example, is how Rona suggested to her friend 'who was interested in Buddhism' that she read 'Sylvia Boorstein's book on Buddhism'²³ which Rona's complementary therapist had recommended. Rona's experience of reading this book gave her 'comfort and just a complete understanding from the start' and led to her becoming interested in and wanting to start exploring aspects of mindfulness.

In other cases, the experience of seeing a picture seemed to lead more immediately to a turning point. For example, when Natasha worked as a graphic designer, her predecessor – who had been involved in designing a book on China – had left behind some of their 'paraphernalia' under her desk. When Natasha saw a picture of China from this book, in a similar way to Lavinia, she became 'fascinated and felt a very strong connection' and 'really felt' she must go to this place.

²² Traditional Chinese Medicine

²³ Boorstein, S. (1997) *It's Easier Than You think: The Buddhist way to happiness*, New York: HarperCollins

Furthermore, while travelling to China, 'somebody had introduced' her to the Lao Tzu Tao Te Ching²⁴. Reading this book was a 'big impactful thing' for Natasha:

having this completely contrasting philosophical stance to everything that I've been brought up with ... the Tao Te Ching which is um about emptiness and the void and it's very different from our very cluttered Western material standpoint in a way and it's about nothingness and the value of emptiness and that I connected with that and Chinese painting.
[Natasha]

These formative experiences highlight how participants – often in their twenties – were beginning to explore different ways of thinking in relation to health and which sometimes highlighted a contrast between Eastern and Western cultures.

Part 2 Supporting my health

Some participants talked about the experiences that led them to search for ways of supporting their health outside of orthodox medicine. Although, these experiences were not always the starting point in everyone's story, they sometimes represented a turning point in their stories.

For example, when Lavinia became 'very ill with hepatitis' during her year abroad as part of her degree, she had to 'drag' herself back with 'very little energy' to do her final examinations. Lavinia had felt at that time there was 'nothing you can do for hepatitis other than rest and allow yourself to get stronger'. However, when 'somebody' suggested to her that she have Shiatsu she thought she would 'give it a go'. Following weekly sessions of Shiatsu, Lavinia described how she felt much stronger and attributed this improvement in her health to how Shiatsu had helped her to 'get back on track'.

²⁴ Addiss, S. and Lombardo, S. (1993) Lao-Tzu Tao Te Ching, Indianapolis: Hackett Publishing Company Inc. This is one of two Chinese philosophers' early works (the other being Chuang-tsu) both of uncertain dates, on Taoism.

During the early 1980s when Natasha was in her early 20s, she went to Thailand and studied meditation in a Buddhist monastery. She felt it all 'tied up very much with that space and emptiness' with which, as indicated above, she felt a strong connection and especially in respect of an Eastern approach to health. This appeared to be a formative experience and led Natasha to choose Shiatsu to support her during a subsequent breakdown.

Following her return to the UK after travelling to China and Thailand, Natasha could feel her 'boat being rocked on some level and had a massive nervous breakdown'. Subsequently Natasha 'had this really difficult year or so with a lot of anxiety and depression and being in hospital':

my mum committed suicide which I think has, I'm sure, has really contributed to my interest in mental health and passion about that and that I think that bereavement and sort of a few years later that catching up with me was why you know ... contributed to my breakdown ... breakthrough. [Natasha]

During the period when she was 'depressed and anxious', Natasha found 'Shiatsu care and support on a personal level very useful and validating'. She found this experience was very different from the 'medical hospital system' where 'doctors were almost frightened' of anxiety and suicidal tendencies.

In contrast, Sally's account of the death of her young son during the 1970s and her 'couple of quite serious illnesses of meningitis and hepatitis' in her young life made her realise that 'you sometimes get things that are out of your control'. Following her experiences, Sally 'went away from doctors for several years' as she thought they were not going to help her. She felt it was 'like a crutch being taken away' from her and a very strange feeling that no one could help her if her children became ill. Sally felt 'out of control' of both her body and her own health as well as the health of her children. Sally's experiences not only 'completely

threw' her 'idea' of how she could maintain her health but also how 'doctors maintain your health'. Her 'realisation' that she 'needed control' over her 'own life and her children' remained for many years.

The experiences of Natasha and Lavinia suggest that although they had found Shiatsu instrumental to their recovery, they had not necessarily lost faith in orthodox health care. In contrast, her significant illness-related experiences led Sally to turn away from doctors and orthodox medicine and left her feeling 'out of control'.

Health-related issues affecting ability to work

Some participants spoke about a health-related issue and how this was affecting their ability to work but also ways in which they were seeking to support their health in this respect.

For example, when Anita 'developed ME' in her mid-50s, it eventually 'got to the stage' where she 'couldn't even do part-time teaching'. She had 'got tired of starting things and then having to let everybody down' and decided 'the best thing to do would be to become self-employed'.

Ellen whose job was in 'script work' was experiencing 'some really terrible repetitive strain injury (RSI) problems' which were affecting her ability to work on computers. She maintained she 'was really suffering in the office' and that she was 'just not meant to be in front of a computer, in air conditioning and those kinds of things'. She felt she probably knew somewhere in her that she needed to get back into her body having been a 'drama therapist for quite a few years'.

Anita and Ellen's accounts both featured their experiences relating to their physical health and which were affecting their ability to work. These experiences were sufficiently serious such that both participants felt they needed to change

their work-related circumstances. While Anita decided she would leave her job as a teacher and saw the way forward as self-employment, Ellen initially was seeking ways to support her health to remain in her job. In both cases, they were seeing Shiatsu as part of their solution to carry on working.

Dissatisfaction with the job

Other participants talked about dissatisfaction with their job and which arguably was affecting their health. In this respect they were positioning themselves to leave their jobs in search of something more fulfilling.

For example, Rona was seeking 'a sense of fulfilment' as her current job in the music industry 'just wasn't exciting at all'. However, she did not think she could afford to give up her job.

Nora was unsettled in her work and she had 'made a commitment' to change her career about two to three years ago. Despite enjoying teaching and feeling she could do it, Nora felt her 'heart was not in it'. She was seeking something that:

sort of aligns like who I am with what I'm doing and you know I want everything to come together you know I don't want to feel fragmented and you know dabbling in this and dabbling in that I want to kind of like hone things in so that I've more of a specific direction. [Nora]

Lavinia and Joan explained how they had become dissatisfied with their respective work situations and felt they wanted to leave.

Joan had been a complementary therapist for about 15 years. She practised a lot of complementary therapies in the place where she used to be employed in the private sector working with 'people with learning difficulties and behavioural problems' and 'found the benefits were tremendous'. However, Shiatsu had been in Joan's 'head and her heart' as one of the things she had wanted to do for many years but had 'not always been in a position to do it'. When she was

nearing retirement, Joan was becoming 'disillusioned with the company' where she had worked for 'many years'. She felt she could no longer 'battle against' what she thought was 'wrong and wasn't getting addressed'. She 'didn't think that the 'service users/clients whatever you want to call them' were 'being treated fairly and with due respect' and this had 'grated at' her for long enough.

During the early 1980s, a few months into her first job after leaving university, Lavinia saw herself as 'quite a free spirit' and realised that the job was not what she wanted to spend the rest of her life doing. She 'was doing a regular class in Okiyoga' at the East-West Centre in London and Lavinia's Okiyoga teacher told her that there was a 'course coming up in Japan in April, in the spring time. It was the first time that the Dojo²⁵, Iokaiyoga Dojo, near Mount Fuji was going to be accessible to foreigners':

and she said 'Why don't you do it, why don't you go' and I thought 'Well why not?'. So I packed in my job bought a ticket to Tokyo and um went. Did the course ... for a couple of months and it was brilliant. [Lavinia]

In both Lavinia's and Joan's case, there is a sense in which they no longer felt compatible with the work culture and which either they did not want to or felt unable to challenge. Captured in Lavinia's sense of being a 'free spirit' which implies a need to be free to make choices – also reflected in Ellen's account of how she was not meant to be in front of a computer – Lavinia and Joan both felt the need to leave their jobs. Reflected in all three participants' accounts is how they were seeking something more fulfilling by way of employment and which arguably was in support of their health.

²⁵ Dojo: 'Do' means 'way' and 'Jo' means 'a place'. In Japanese a Dojo is a place where one comes 'to practice the way', referring to the inner spiritual development one may be seeking to achieve through the particular 'way'.

Part 3 From supporting oneself to supporting the health of others

Many participants found some Shiatsu-related physical experiences really empowering and which led to a sense of how they how they wanted to use Shiatsu to support the health of others.

For example, during the 1970s, after teaching in a school for a short period, Leo began studying for a post-graduate degree. During this time he went to Paris and studied with Akinobu Kishi who was an internationally renowned teacher and master of Zen Shiatsu. Leo's reflections on this experience were:

just a door opened ... that it was a whole ... there was a whole connection to Chinese Medicine and um stuff like that so I suddenly thought this is something that's worth studying not just something I know how to do.
[Leo]

Leo's experience of studying with Akinobu Kishi in Paris is reflected in others' experiences around this time, as indicated in published accounts within the Shiatsu Society (UK) News. For example, Rose (2007) had spent a year in Japan studying with Masunaga Sensei²⁶:

for my first month in Tokyo I sat silently every day in a corner of his clinic and just watched and watched and watched ... [p. 8]

Similarly, following experience of her first Shiatsu workshop with Wataru Ohashi, Carola Beresford 'hasn't looked back' (Beresford-Cooke 2007, p. 10). Thus, a key turning point for Leo was his experience of Kishi's workshop reflected in his comment 'just a door opened'. The ideas behind Shiatsu resonated with his own and made sense to him.

²⁶ Teacher in Japanese

During a similar period in the 1970s, Madelaine had 'always fancied doing Massage' and had 'bought books on it' but Madelaine felt that 'following the books doesn't give you any idea of what you are doing or how hard to press or anything'. Thus, during the early 1980s, when 'somebody had organised a Shiatsu weekend', Madelaine 'went along':

and I felt I was young and healthy and fit when I started but by the end of the weekend I felt fantastic and I thought 'Oh there is something going on here!' And it just sort of snowballed from there really. [Madelaine]

Prior to that weekend, Madelaine had not experienced Shiatsu before and 'that's what did it' for her. Like many other participants, Madelaine's first experience of Shiatsu appeared to have quite a profound effect on her but despite this experience, in a similar way to Leo, she 'wasn't expecting it to turn into a career'.

Similarly, it was Joan's first experience of Shiatsu 'many years ago at Glastonbury' that not only had a lasting and significant effect on her but also caused her to think that this was something that she would like to do to support the health of others at some point in her life.

Lots of powerful stuff coming up

Leo's experience of a 'door opening' is mirrored in other participants' more recent accounts of their experiences at retreats.

For example, Ellen sought a Buddhist retreat in the UK 'for the meditation thing' to help her cope with a RSI. Although it was primarily the meditation that attracted Ellen to the Buddhist retreat, it was run by a Shiatsu practitioner who was using Shiatsu to 'deepen meditation practice'. It was through this experience that she came across Shiatsu for the first time and which subsequently led her to become interested in the physical work:

each day of the week the [Shiatsu] practitioner talked us through one of the Five Elements²⁷ approach and we did a little bit of Shiatsu and she was the most amazing teacher. [Ellen]

Ellen described how when it came to the 'Metal day'²⁸, and the teacher talked about bereavement and loss, 'lots of powerful stuff was coming up'. The experience of the Metal day led Ellen to think there might be a connection to a family bereavement she had experienced some years ago:

Oh my God, my RSI was a sort of accident waiting to happen and maybe I can't blame my employers totally and maybe you know it has an emotional aspect to it. [Ellen]

Ellen found this experience 'really empowering and really exciting'. It led her to think that maybe there was another way of approaching her RSI 'problem' which was preventing her from writing and about which she was 'really desperate'. She felt it had connected her to Shiatsu in how it provided a meaningful way to think about her health. This experience inspired her to consider training in Shiatsu. She described how she went to one taster day in London and then with 'not a lot of thinking, just went for it and ended up working really hard on a three year Shiatsu course'. Ellen never worked out the cost of Shiatsu training – she was 'really doing it' for her own health. She was not necessarily considering Shiatsu as a career, at least at that point, but rather using Shiatsu to support her and enable her to continue with her current work.

Many of Ellen's experiences of attending the Buddhist retreat are echoed in Nora's very detailed account of her experience of attending a retreat. Unlike Ellen who was seeking an experience to support her in her current situation, Nora was specifically looking for an experience that would extend and challenge her. In her early 30s and a part-time teacher, Nora was studying for a Masters degree in

²⁷ For explanation of Five Element theory, please see Appendix 02

²⁸ 'Metal' is one of the Five Elements

transpersonal psychology. As part of her Masters degree, Nora chose an 'experiential fieldwork module' because she felt she was someone who found it 'very easy to live inside her head and inside books' and she wanted to do:

something that was gonna really challenge me to move beyond my comfort zone of my particular way of relating to the world at the moment.
[Nora]

She felt that transpersonal psychology was quite spiritual and although she 'already had meditation practice and Yoga and things like that', she was seeking to 'absorb herself into something'. After researching the internet she found a 'Shiatsu and Chi Gung retreat' in a 'really, really beautiful' location in the north of the UK.

Like Ellen, Nora 'didn't know anything much about' either Shiatsu or Chi Gung and considered Shiatsu to be a 'kind of massage type of thing'. Indeed she 'purposefully wanted to keep it that way'. Furthermore, Nora had not realised that she would be doing 'massage or bodywork' and when she arrived at the venue, 'it sort of hit' her that she was going to have to get over her inhibition and 'such slight discomfort of moving into somebody's person space' and interacting with them in a really personal way. This realisation 'pushed' her out of her 'comfort zone':

I can't tell you how um not me it is to engage in a practice that involves physical contact. [Nora]

As a consequence of this experience, Nora felt 'quite vulnerable and exposed to a new way of being' with herself and in relation to other people.

As if somebody has just come up and adjusted the lens

In a similar way to Ellen's experience, during her week-long stay at the retreat, each day Nora and others 'explored one of the Five Elements'. They would sit in

a circle²⁹ and talk about the 'sort of emotional things that were connected to a particular element'. On the final day of the retreat, they did a full body treatment using all of those five different meridians³⁰ that they had got to know over the course of the week.

Despite her discomfort in respect of the physical work, Nora 'really really enjoyed' the retreat. She found it to be 'quite a spiritual experience' in that she felt it quite 'sacred to be working with somebody else's body and in that close way':

like it was a privilege to work with people like that and there's a lot of trust involved isn't it ... somebody's trusting you and you're trusting them you know and there's vulnerability and tenderness to that I think it's not present in a lot of other things that you do. [Nora]

Nonetheless, Nora 'just hadn't imagined it to be a big experience' as she had just thought 'Yes I'll go and I'll do it and it'll be nice'. She had not imagined that it was going to change the direction of her career.

During the week Nora had begun to wonder what might be involved in doing Shiatsu training and sought advice from the person running the course and who Nora considered to be 'excellent'. As she drove home from the retreat, and reflected on her experiences, in a similar way to Ellen and Natasha, Nora found the 'different ideas and associations' of the things she had been studying and things that she had come across in her life 'coming together and making sense':

I'd you know started to understand through the Five Element Theory and Chinese Medicine um approach and yeah and just thought this is really making ... like it was as if somebody has just come up and adjusted the lens or something. [Nora]

Encountering Shiatsu at their respective Buddhist retreats led to major turning points for both Ellen and Nora – in the sense that they represented profound

²⁹ For fieldnote on the Shiatsu practice of sitting in a circle, please see Appendix 09

³⁰ For explanation of meridians, please see Appendix 02

experiences and specifically their experiences of Shiatsu. In both cases, these profound experiences were not only new, but also exciting and meaningful – particularly in how the philosophy and ideas underpinning Shiatsu enabled them to make sense of their own and others' health and inspired them to think they might use Shiatsu to support the health of others.

Linking body and mind

Although Nora was clearly initially very wary of engaging with people in a physical way, she reflected on how these experiences were meaningful in a spiritual as well as a physical sense, highlighting the link between body and mind. Other participants were also specifically interested in the link between Shiatsu and mental health. For example, since her 'breakdown-breakthrough', Natasha had always been very 'interested in mental health because she felt that Shiatsu had something very specific to offer in that area':

I had er 'lived experience' er which thankfully nowadays is a bonus as opposed to a problem um and I just thought what a fantastic practice Shiatsu is to really support people ... there's a lot of stuff about recovery and um staying well and empowering people and self-care and so it's totally in line with current policies. [Natasha]

She was very clear that this was the field where she wanted to head and started 'building' towards her goal by doing a 'few lectures for nurses and some talks for mental health charities such as Outpatient Mental Health Women's Groups'.

Similarly, Olivia who saw herself as a 'bit of an alternative thinker' and open to other ways of 'looking at health', was 'very interested in the kind of crossovers with mental health and physical health'. She perceived a 'barrier between the physical health care and the mental health care side of things in the mental health services' and she felt that many people had 'quite unaddressed issues' in

this respect. Thus, linking body and mind formed another important influence toward becoming a Shiatsu practitioner.

Inspired by people

Many participants mentioned how they had been inspired by people and this occurred particularly around turning points when they used the voices of others, often to justify or strengthen their choice of direction. For example, both Nora and Ellen appeared to be impressed by the person leading the retreat, and particularly in Nora's case stimulated her intellectual curiosity to pursue her interest in Shiatsu. Other participants described similar experiences. For example, Stephanie was particularly influenced by the person running the course and attributed her influence as key to her decision to train in Shiatsu. Stephanie accounted for how she 'first got into Shiatsu' or thought she had 'even heard about Shiatsu' when doing a Yoga course as she thought she 'might train to be a Yoga teacher'.

the lady teaching that course was actually a Shiatsu practitioner as well [as a Yoga teacher] and so every now and again she would, you know, throw in a little snippet of 'If you press this point or push this it's working that meridian or in Chinese Medicine they say this' ... so that just really got me sort of interested I think um ... into doing Shiatsu. [Stephanie]

In contrast to the immediate and quite profound experiences of Nora, Ellen and others, despite 'having complementary therapies for the last 12 years' Rona 'didn't really sort of know' what she was 'having' and 'never questioned it'. However, echoing Nora's comment, 'somebody's trusting you and you're trusting them', Rona felt that her life was 'really inspired' by the complementary therapist. There was 'complete trust from the start' and she 'spent years not even questioning' 'What are you doing?', 'Why are doing it?', because it 'just absolutely worked' for her.

Thus, for some participants their Shiatsu-related physical experiences were very powerful motivating forces in leading them to think about pursuing Shiatsu further. Additionally, in some cases, people who were already trained in Shiatsu or complementary therapies inspired participants to consider signing up for training.

Part 4 Seeking Shiatsu as a qualification

This part takes a step back to the 1970s, and begins by considering how – as outlined in Chapter 2 – the Shiatsu community began to formally unite and generate a training programme. In 1978, 'along with six people' (including Carola Beresford-Cooke and Michael Rose) who had studied Shiatsu in different places in the world, Leo described how they formed a 'core group' and met every Tuesday morning in 'Mike's flat'. They taught each other what they had studied from different teachers. Leo acknowledged that they 'were not the only people doing Shiatsu' but maintained that their group 'was the sort of core'. As such, he suggested 'this was how it all started' and was their 'training course'. Furthermore, 'about one year later', these six people, including Leo, started to teach Shiatsu:

we weren't the only people doing Shiatsu but that was the sort of core and then we started teaching after about a year ... we started teaching groups and those students then asked us to form the Shiatsu Society which we did ... so that was, that's how it all started. [Leo]

Thus, Leo was one of the prime instigators of Shiatsu training in the UK as well as in the formation of the Shiatsu Society (UK) in 1981 representing a key turning point for Shiatsu in the UK.

Early training trajectories

Madelaine's experiences, however, illustrate how not everyone who was interested in Shiatsu training around this time was aware of the existence of the Shiatsu Society (UK) training programme. Madelaine's experience during the late 1970s and early 1980s was that 'there weren't any proper training courses at the time'. She 'just kept on doing weekends with anybody and everybody' until someone told her about the Shiatsu Society. It was at this point that Madelaine decided to seek a formal qualification and undertake her 'first assessment'. She described that she 'got there' by just doing 'bits' that had been 'put together' by different teachers. Thus she completed her Shiatsu training by doing 'sufficient hours with enough different teachers to make up the time':

and it was verbal questions and practical at the time ... it all happened at the end of a workshop. There were a few of us who did the assessment at the end of the workshop it was very different from wherever we are now 30 years on. [Madelaine]

In contrast, Lavinia's experience of learning Shiatsu during the early 1980s was first by travelling to Japan to join a Dojo having left her first job following university. Here she began to develop her Shiatsu practice. At the Dojo there were people from 'all over the world, a large contingent from Australia, some from America, a lot from Europe' revealing an international interest in Shiatsu:

we did lots of Shiatsu, we did herbs, we did some fasting, we did a lot of meditation ... there were also classes in Ikebana³¹ and the tea ceremony and um we lived the Dojo life so we'd wake up very early and meditate for an hour etc um anyway by the time I'd finished the course I really felt that I wanted to learn more about Shiatsu ... in ... just purely Shiatsu. [Lavinia]

After living in the Dojo for two months, Lavinia remained in Japan for a while teaching English and experiencing the Japanese culture. Reflecting the experiences of Leo and colleagues, she continued to study Shiatsu 'with different

³¹ Ikebana – Japanese art of flower arrangement

teachers in Tokyo' some of whom were students of Masunaga (one of the influential figures involved in bringing Shiatsu to Europe). Lavinia's experience at the Dojo appeared to really inspire her and she became 'totally committed to Shiatsu' which indicates a turning point in her life. After being abroad for about 'two and half years', Lavinia returned to the UK. As mentioned in the introduction, there were many different styles of Shiatsu being taught and Lavinia was drawn to Sonia Moriceau through the recommendation of a friend:

I thought I knew everything about Shiatsu and was thinking about doing an acupuncture course [laugh] and he [a friend] said 'why don't you go and see Sonia [Moriceau]' ... and so I did go and see Sonia and chatted with her. I had a session with her and then booked in on her ... a 2½ year training and I finished that in 1988 and that was when I felt that I had ... well actually had a formal qualification as well for doing Shiatsu and so I've been practising Shiatsu ever since. [Lavinia]

Lavinia's account illustrates that not only was she drawn to Sonia Moriceau as a charismatic leader, but also to her particular style of Shiatsu. Furthermore, reflecting Madelaine's desire to engage with training, Lavinia also felt it was important to have a qualification to increase her credibility and acceptance as a Shiatsu practitioner.

Signing up for Shiatsu training more recently

This section considers other participants' more recent experiences in relation to seeking to train in Shiatsu. For some participants, Shiatsu was a very 'focused goal' whereas other participants wavered between choosing Shiatsu and another therapy or were seeking Shiatsu as a means of 'broadening their therapy belts'. Other participants who were in need of paid work saw Shiatsu pragmatically as a way of being self-employed and earning a living.

Shiatsu as a focused goal

Joan had 'always been one of those people that always wanted to try something before actually committing to it'. She was passionate about Shiatsu and having made the decision to quit her job, Joan thought she would 'do something really mad before she retired'. She decided to 'tie it up with a degree' as this was something she had always wanted to do but had never had the chance having left school at the age of fifteen.

In contrast to Ellen's 'quite haphazard, just went for it' approach, Joan felt she took a very 'considered approach' but also 'took a big step, a big leap' maintaining that she had 'always been too cautious in the past'. As she had the full support of her husband and family she thought:

well why not do it ... you're never too old you know so here I am ... it's done ... I've always been interested ... always been interested for many many, well most of my adult life. [Joan]

Consequently, Joan started searching for university courses and finding a course at a university 'not too far away which included Shiatsu', she subsequently signed up.

Nora's experience of the retreat had led her to want to pursue Shiatsu as 'quite a sort of focused goal'. She felt Shiatsu aligned with her philosophy to do with health care and linked her interest in mental health. For some time, Nora had felt 'strongly' that although she did not 'disagree with prescribing drugs' and thought that this approach was very 'valid and important', she also thought that 'in our ways of working we don't always necessarily dig around enough to get to the root of the problem'. Nora thought that 'Shiatsu has something that it can offer to complement Western [Medicine]':

it's like an East meets West kind of thing. [Nora]

Although Nora did not feel that Shiatsu would be suitable for 'absolutely everybody', she felt that it was 'ticking a lot of boxes' for her in respect of interests and career goals. Pursuit of Shiatsu was 'a whole body decision' and about wanting to do 'something' that was from the 'depths' of her soul.

Nora's positive experience at the retreat and her respect for the person running it were important influences in respect of her decision to pursue Shiatsu 'professionally' as well as gain 'some lifestyle'. However, there were a number of other factors guiding her decision. Like other participants, geographical location was an important consideration and in Nora's case she wanted to be near her family. Furthermore, she wanted somewhere that reflected her own research interests in 'transformational work and personal self-development'. However, what appeared to seal her decision was the positive contact she had with the principal of one of the schools and with which she eventually signed up. She reflected she was 'pleased' that she did make that choice and felt it was the 'right place' for her to be doing this 'at the moment'.

Reading a particular leaflet became a turning point for Sally. She described herself as 'a habitual leaflet picker-upper' but she never really read any of them properly. Following her return to the UK during the late 1970s, Sally 'dabbled' in 'loads of different therapies' and 'read books that people recommended'. She 'went on courses and attended seminars but did not actually do any training'. Although she was 'fascinated' by all of these experiences and 'learned things', she 'couldn't find anything that quite worked' for her.

She had been searching for many years for a meaningful way to support her health and that of her family, when one particular day as she was tidying up her room she came across a big stack of leaflets. Sally's attention was drawn to a Shiatsu leaflet which included a quote by a mother of three children:

.....it was just right for me because I could train at weekends it wasn't full time and it appealed to me because it was getting in touch with my own health and that of my family and it meant that I could look after my own health um and that of my children in the first instance at least. [Sally]

These words had a particular resonance for Sally, in that she perceived Shiatsu would 'just enable her to have this control'. Sally felt 'really inspired' by the leaflet and decided to pursue her feeling that this is what she been 'looking for' and rang the number on the leaflet. She wanted to find out if they were running any training nearer to where she lived because it would have been 'a lot of hassle' and 'quite a commitment' to travel to London. When the school responded that they did not 'have anything outside of London', Sally contacted the Shiatsu Society (UK) and based on information they gave her, located a nearby course which was 'going to cost about £3000'. At this point Sally had not 'even had a Shiatsu' and 'knew nothing about it' apart from what she had read in the leaflet. Based on the experience of 'about a 10-minute Shiatsu' Sally decided she would 'go for the introductory course³² initially and went 'from leaflet to course within about 10 days'.

Sally's experience of signing up for Shiatsu training appeared to be a significant turning point in that she had finally found something she had been looking for. Although Sally signed up mainly due to the appeal of the information leaflet and how this resonated with her, geographical location – in the sense of being able to train as near to home as possible – appeared to be another important consideration. In this sense, Sally was acting pragmatically. It is notable that after only a 10-minute session of Shiatsu (which was her first experience of Shiatsu), Sally was willing to sign up to the introductory training. This suggests that after many years of seeking something meaningful to support her health and that of

³² As outlined in the introduction, this is series of just a few weekends.

her family, this experience must have been significantly convincing or the person providing the session was highly persuasive.

Thus, not only do these participants' stories illustrate how Shiatsu appeared to be meaningful in how they identified with the ideas and the philosophy underpinning Shiatsu, but also there is a sense that – even with the more considered and thorough approaches of some participants to finding the right place to train – once they had hold of the idea that Shiatsu was what they wanted to pursue, then, in the words of Nora, signing up for Shiatsu training appeared to become a 'focused goal'.

Teetering between Shiatsu and another therapy

On the other hand, some participants wavered – at least initially – between choosing Shiatsu and another therapy for varying reasons.

For example, during the late 1980s, after returning from abroad and finding the experience of Shiatsu very helpful during her recovery from her breakdown, Natasha was considering training in Shiatsu. She was aware of the Shiatsu Society and its training programme and although she was considering doing her training at one of the now established training schools, like Lavinia, she was contemplating whether to do Acupuncture instead of Shiatsu. Natasha spent a bit of time 'teetering on which way to go'. She 'landed on the Shiatsu front' through being influenced by a friend who recommended that the 'touch element' would suit her better as this was her 'strength'.

However, what finally persuaded Natasha to start Shiatsu training was through the recommendation from a woman who she 'respected very highly' and the fact that she could support herself through other work during the part-time, two-year training programme. Then aged 24, Natasha felt she was 'blessed' because she had not got a 'mortgage, family and was still sort of studenty age'. Despite her

enthusiasm to embrace new ideas about health Natasha felt that some of her friends thought she was 'quite odd':

you know 'Oh my god she used to be really groovy and now she's become one of the weird people, go the East and come back like this other creature' [laugh]. [Natasha]

Although both Natasha and Lavinia were undecided for a while between Acupuncture and Shiatsu this did not appear to be because Shiatsu was not important to them. In Lavinia's case she thought she knew all there was to know about Shiatsu, and Natasha had grown interested in Acupuncture through experiencing it. Respect for and liking of the person leading the training appeared to be a significant determinant in both Lavinia and Natasha's choice of where and with whom to train, reflecting perhaps the influence of charismatic leadership. Furthermore they both appeared to be influenced by the recommendations of friends.

Following her experiences on the Yoga foundation training course and although she completed the course, Stephanie decided to go 'down the Shiatsu path' instead of pursuing further Yoga training. Her decision to pursue Shiatsu was partly through being inspired by the person leading the Yoga training and her preference for the 'one to one situation' of the Shiatsu practitioner-client encounter. On searching for a Shiatsu course, like Sally and Nora, geographical location was important and furthermore, Stephanie felt that not being 'part of a big chain' also meant the course 'offered a little bit more as it had all these extra workshops' that might not have been available if she had gone to another school.

When Kat was 'looking for uni courses' she 'knew' she wanted to do something with complementary therapies because she had 'just grown interested in that'. She 'heard that there was a complementary therapist degree' at her local

university and she decided that this was where she was going to go because she 'didn't want to move away from home'.

As such, Kat only applied to her local university to study 'complementary therapy' so 'everything rested on getting into that uni'. When she went to the interview the admissions tutor (and future lecturer) explained there were two pathways, a Shiatsu pathway and the Reflexology/Aromatherapy pathway. With little idea of what Shiatsu was about, Kat was contemplating going into the reflexology pathway. However, during the interview:

something my lecturer said ... something about like 'It's [the reflexology pathway] a very popular pathway' and I don't like being in lots of people I like to be in a small group so I says 'Well I'll do the Shiatsu pathway then'. [Kat]

Thus, in a similar way to other participants for whom geographical location was an important consideration in choice of training school, Kat based her decision to study her degree close to home and pursue Shiatsu on the basis of preference for smaller groups.

Anita 'quite fancied the idea of Acupuncture' and on discovering that her local university 'was advertising itself in the clearing thing as doing Acupuncture', Anita 'phoned up to find out about it':

the programme leader at the time said 'Oh well we didn't get that course accredited but you can do Shiatsu' which up to that moment I have never heard of so I kind of said 'Oh alright then I'll do Shiatsu!'. [Anita]

Thus, Anita, somewhat serendipitously ended up 'suddenly committed to three years of Shiatsu' without any knowledge of Shiatsu which she 'didn't think is the way people usually do it'. Although this is similar to the way in which other participants described how they signed up to Shiatsu training (for example, Sally

and Ellen), in Anita's case her decision was quite pragmatic in that it appeared to be connected to her need to become self-employed.

On the other hand, and as a consequence of her 12 years of having complementary therapies and how it 'absolutely worked' for her, Rona felt she 'always knew' that she would eventually train as complementary therapist 'later on in life':

I'm 42 now and I didn't quite expect ... I think sometimes you don't realise what your age is so you have this expectation I'll do it later on in life and then you realise 'Oh actually I probably am later on in life now and it's time to sort of start training in it'. [Rona]

Rona's partner had noticed a 'change in her personality' when Rona had changed jobs and she was becoming unsettled in her job. Although Rona had concerns about whether she could afford to give up work, her partner observed Rona's 'passion' for complementary therapies and suggested to Rona that she pursue her interest in training in this respect.

Thus, like Joan, Rona had the support of her partner and this helped her to decide to start looking for training courses. Rona 'quite literally just did a Google search' thinking she would 'probably find an evening class and combine it with a full-time job'. She 'never had the expectations to do a degree' but when she 'came across the degree course' at her local university she 'just went for it'. When she began her search for a course on complementary therapies, Rona's focus was not necessarily on Shiatsu. However, unlike Anita who settled on Shiatsu almost by default, Rona chose Shiatsu in preference to the Aromatherapy/Reflexology route because 'the ideas behind it just fitted' in with her own. Furthermore, she saw Aromatherapy as 'more sort of health and beauty orientated' and she was more interested in exploring something that would enable her to go 'more deeply' into bodywork.

Sheila's housemate had persuaded her to think about 'going back to school'. In her early 30s, Sheila found the idea of university 'a little bit scary'. Despite this feeling, Sheila undertook an access course to 'get some academic confidence back'. When completing her UCAS application, Sheila contemplated what she could do that 'will benefit people in need'. She really wanted to go and work in 'Third World countries' and wondered what skill she could learn that would be 'really well accepted'. She considered Podiatry as a first choice because she did not 'have an issue with feet and it was medical but not a doctor'. However she had 'always enjoyed complementary therapies' and as she had a 'Diploma in Indian Head and in Body Massage' and being keen to pursue 'that side of things', she searched the internet for universities offering 'complementary therapies'.

It was a 'toss-up between Acupuncture and Shiatsu' but as Sheila was 'quite interested in equine Shiatsu', she decided she would go to the interview 'and see what happens'. However, unlike Anita who signed up immediately after the interview, Sheila had 'real reservations' as to whether she had picked the right path or not. She knew 'in her heart' she had 'made the right decision' but her 'head was still fighting it' because of 'all the practicalities and the things' that she could not do and how she might be limited in relation to her ongoing Psoriatic Arthritis (PsA)³³.

Consequently, Sheila 'just let things stew for a few days' and decided if she still felt she 'had reservations after about two weeks' then she would 'seriously put movements into place to change it'. After due consideration, she felt she had 'picked the right path'. Despite having made her decision, it was only at this point that she thought she should go and have a Shiatsu treatment:

³³ Psoriatic arthritis (PsA) is a disease where joints around the body become inflamed and sore. It can make moving about difficult and painful. People who have PsA also have (or will develop) the skin condition psoriasis [Source: <http://www.nhs.uk/conditions/psoriatic-arthritis/Pages/Introduction.aspx>]

You know that's funny I kind of made the decision and then I thought 'Perhaps I ought to have one to know what it's about?' [laugh] and then I went and I had one and I did walk away thinking 'I'm not sure about this' um but kind of the ball had really been put in motion. [Sheila]

Thus, although Sheila was trained in other therapies and arguably at some level, she was looking to 'broaden' her 'therapy belt' – despite her reservations in respect of her concerns about her physical health – she was instinctively following her 'heart' in choosing to train in Shiatsu rather than Acupuncture. As such, this decision appeared to be more pragmatic than simply involving an alignment of her philosophical beliefs and the ideas underpinning Shiatsu.

In contrast, stemming from her primary motivation to become self-employed, Anita readily switched from her first choice of Acupuncture to Shiatsu despite her lack of knowledge about it and, like other participants, she signed up quite rapidly from the point at which she first made her enquiry. Although she seemed to question at one level whether her younger contemporaries might think differently, Anita nonetheless felt justified in pursuing Shiatsu training as, like Joan, she felt there was a 'future of some kind that fits in with life'. Nearly thirty years younger than Anita, Sheila's primary concerns seemed to stem from her lack of academic confidence, potential issues in relation to her physical health and a desire to pursue a complementary therapy that would be well accepted. Sheila's latter concern did not appear to be a consideration of Anita's, which is reflected in her readiness to sign up for Shiatsu despite knowing nothing about it. On the other hand, despite not experiencing Shiatsu directly but through reading about it, Rona felt that not only the ideas behind Shiatsu made sense to her but would also enable her to explore her interest in bodywork more deeply. Furthermore, her choice to pursue Shiatsu was influenced to some extent by the way she looked somewhat disparagingly toward the other therapies on offer.

Broadening their therapy belts

Some participants' primary motivation appeared to be about 'broadening their therapy belts'.

For example, Megan had 'like a goal' since she was about nine years old to work in 'beauty and that kind of industry'. When she was at college doing her 'A' levels and was 'going through the different modules' she found that she 'favoured the massage kind of side of it'. After completing her 'beauty therapy level 3 and holistic level 3' she 'kind of wanted to learn more therapies'. When her teacher was explaining the different courses on offer at universities, Megan became interested in 'Shiatsu and Reiki and all these other things'. She 'guessed' her motivation to sign up for Shiatsu was just 'kind of to broaden' her 'therapy belt'.

Rita was a 'trained reflexologist' and had also trained in 'other complementary therapies'. She mentioned several experiences that led to her signing up for Shiatsu. During her training as a reflexologist one of the other students happened to talk about his experiences of Shiatsu and how 'it had made a significant difference to him'. Rita was also friendly with one of this student's friends who had started going for Shiatsu treatment and had subsequently gone on to train in Shiatsu and 'really enjoyed it'. At this point, Rita 'didn't really know what Shiatsu was all about' other than she 'knew it was some energy work'. After training in reflexology, Rita began to train in Massage. It was during this training that her tutor suggested to her that she might like to consider training in Shiatsu as she was already trained in quite a few therapies. Rita decided that she would pursue Shiatsu and began to investigate Shiatsu training at her local university.

Although Megan and Rita's accounts refer to the people who had influenced them, in Rita's case she makes fairly extensive use of other voices and other people's experiences to tell her story as if, in a sense, this lends weight, gives

more credibility to and justifies her decision to add Shiatsu to all the 'stuff that was up her street'. To some extent, however, Rita also indicated how chance encounters played a part in leading her to sign up for Shiatsu.

Although not exactly looking to broaden her therapy belt but more to pursue her interest in looking at alternative ways of supporting people's mental health, Olivia seized a serendipitous opportunity to train in Shiatsu when it arose in her workplace. In her workplace Olivia had a friend who 'was a member of a working party that was looking at introducing a policy to ensure the safe practice of therapies in the Trust'. The working party 'developed like a list of different therapies which either people were qualified in or seemed to be suitable and there was a pot of money attached to this'. Olivia explained that Shiatsu was included on the list because it was being used by a Shiatsu practitioner in the Trust who worked in the drug and alcohol area and seemed a 'really ideal therapy'.

Although Olivia 'hadn't even come across Shiatsu before' she had been doing Tai Chi and Kung Fu and had a 'kind of oriental appreciation of health and sort of messed about with kind of intuitive feeling stuff' and felt this is what attracted her to doing Shiatsu. She 'kind of jumped at' the chance to train:

so um they basically said 'Well we've got this list of therapies does anybody want to go and do some training?' and I'm like 'Yeah I'll have a bit of that' so um they um the Trust at the time funded me 75% of my Shiatsu course over 3 years with a view to me using it in the day centre where I worked ... [Olivia]

Thus, these participants were looking to extend and develop what they were already doing by way of their practice and particularly in relation to CAM. They were not specifically seeking to train in Shiatsu but almost serendipitously they ended up signing up for it.

Being jobless

Maggie and Sheila's experiences of being jobless led to their engagement with Shiatsu. For example, Maggie's interest in Shiatsu started in 'a totally serendipitous way' when she was made redundant from her 'science-based work' while in her mid-40s. She had moved from 'company to company' every five to six years and considered herself 'lucky' in the sense that she had gone 'through a phase' in her life when she earned 'lots of money' and travelled round the world so had 'got that out of her system'. The 'only decision' Maggie made was that she 'wasn't going to go into the same line of work' yet she wanted to get a 'proper job' and considered herself fortunate in that she had some money saved up and was in a position to 'cut her cloth accordingly'.

When Maggie was 'sort of looking around' for a 'proper job', she met a friend at Tai Chi who suggested that she 'really ought to try Shiatsu'. Coming from a 'science background', Maggie was 'very, very cynical' about how it was possible to 'feel Ki moving and things like that' and thought sarcastically 'Yeah right!'. Furthermore, she felt that Shiatsu sounded like 'airy fairy' stuff and in response to her friend's suggestion to try Shiatsu, Maggie 'told' her:

'No don't be silly I've got to get a proper job'. [Maggie]

On the other hand, Sheila had been 'kind of aimlessly moving through life doing various jobs and through personal circumstances ended up kind of homeless, jobless'. Eventually, she had taken a job at Tesco 'doing very menial work' because she 'wanted to switch off' and that was her 'main aim'. Unlike Maggie, Sheila had 'always enjoyed complementary therapies'. Finally, her 'housemate kind of pushed' Sheila by telling her 'You know you do actually have half a brain' and suggested that she should 'go back to school'. Nonetheless, Sheila was wary of this suggestion:

being raised in South Africa, university is something you do directly after school you know you do it when you're 18 and 19. I'm now in my 30s so the idea of university was a little bit scary. [Sheila]

Thus, Maggie is clearly positioning herself as coming from a scientific background, and despite her decision that she would not go into the same line of work she implicitly conveys a sense through her cynicism of the notion of Ki that she still considers scientific thinking to carry greater credibility. This is reflected in her robust retort to her friend's suggestion to consider trying Shiatsu.

Furthermore, Maggie positions herself as confident and also fortunate in having travelled and saved up some money. She conveys her redundancy as almost an opportunity for change. On the other hand, Sheila portrays herself as lacking in confidence reflected in the way she described how her housemate needed to 'push her' and notably she appears to be in a less fortunate position to Maggie by way of disposable income.

To some extent, Maggie's experiences reflect those of Anita in that both were seeking a different kind of work. However, in contrast to all other participants, she stands out as not only presenting herself as being from a 'scientific background', but also as wanting to show that she initially rejected and was quite cynical about therapies such as Shiatsu. In this sense Maggie is not broadening her therapy belt or choosing between different therapies and furthermore, she presents herself as confident in these aspects. Nonetheless, despite her views, persuaded by her friend, Maggie decided she would 'try Shiatsu' and used the money she had saved in a building society which was the 'equivalent of the first term's fees and travel' to where she was going to be training. Maggie was very clear that she had 'no expectations at the time' because she embarked on the training 'not ever thinking she was going to be a Shiatsu practitioner'.

Part 5 Shiatsu training as a ‘vast toolbox’

This final part focuses on the recent experiences of students during their training and highlights the positive as well as the more challenging aspects. As discussed earlier, adopting the process of professionalisation based on mainstream health care was an attempt by CAM therapies to gain legitimacy and part of the legitimising strategy was to include aspects of Western medicine within the curriculum – for example, anatomy and physiology (Cant 1996). As such, in addition to studying the traditional theories and practice of Shiatsu, the training programme developed by the Shiatsu Society (UK) required its students to demonstrate a knowledge and understanding of anatomy, physiology and pathology (as indicated in Appendix 01 – Baseline Syllabus).

As discussed, for some participants their motivation to train in Shiatsu was linked to a way of developing themselves. For example, Doris had always been interested in learning ‘new things either about things in the world’ or about herself so had been open to transformation and developing herself. Similarly, Nora’s interest in Shiatsu was associated with her interest in spirituality and, like others, she perceived Shiatsu as being very linked to a ‘spiritual practice’ which was about self-exploration through delving into their own experiences.

As such, many participants, particularly in their first year of training, expressed a hunger for learning in relation to different ways of thinking about and experiencing, as well as making sense of, their own and others’ health. For example, ‘encountering Shiatsu’ – a new therapy for many – was ‘fascinating’ and ‘all-absorbing’. Studying the theories of Yin and Yang and the Five Elements from Chinese Medicine that underpin the philosophical principles of Shiatsu presented a new and different way of thinking and, for many participants, represented a ‘whole different approach’ to Western medicine. Similarly learning and

experiencing the different ways of practising Shiatsu, for example Zen Shiatsu, 'opened their eyes' to different kinds of bodywork practices. For some participants, particularly those who had experienced Shiatsu prior to training, experiencing these culturally different understandings of health felt like 'coming home', having found 'something they had been searching for' as illustrated by Sally reflecting on her first day of training:

I met XXXXX on that first day and we were partners. And aaah he was so lovely and I just loved everybody there and I loved the whole environment it was ... at this village hall and we took food to share and I just loved it and it was my kind of people and I felt I'd come home and I also felt that it embraced everything I wanted it to do ... that Shiatsu was not just another thing like Reiki or Crystals or Reflexology it was a way of thinking and a way of life and a way of feeling and a whole different approach ... it was a new and completely different way that turned everything on its head ... it also made complete sense of everything and that for me was Shiatsu, the joy of Shiatsu. [Sally]

Similarly, more recently after her first weekend of training Nora 'kind of felt like she was moving into a group of people who she felt she would 'really be able to relate to and link with'. She felt really 'positive and excited' about all that she was going to learn. In contrast to those participants seeking Shiatsu as 'a spiritual thing', along with some other participants, it was not intellectual or spiritual curiosity that drew Anita to Shiatsu but rather a pragmatic need to find something that would enable her to earn a living. Furthermore, Anita stands out in how Shiatsu training was her 'plan Z' as by then she had 'gone through all the other plans'.

Despite some participants' excitement and enthusiasm for Shiatsu, their experiences also highlighted challenges. For example, increasing the number of practice treatments caused some students to feel under pressure (discussed further in the next chapter). Additionally, some student participants were wary about entering 'this new and different world' where there were 'competing and

contrasting bodies of knowledge'. For example, it was hard to reconcile and see the 'connection' between a body of knowledge around anatomy and physiology based in a Western medicine scientific framework and the more esoteric yet 'compelling' bodies of knowledge associated with Shiatsu theory and practice. Although it was often the latter body of knowledge that represented the 'draw' in how it became a meaningful way to finding out about themselves, it was also the challenge because of its uneasy partnership with Western medicine.

For example, Rona reflected that 'you have your own sort of vulnerabilities or lack of confidence' and felt that 'probably in the first year of training' she was a little bit 'like a sort of rabbit in the headlights' and she felt that a lot of herself had been 'pushed to one side' during her first year. Some participants felt overwhelmed by the amount of new knowledge. For example, during her second year, Sheila found it 'hard to get to grips with so much information to take in' and particularly 'found Zen very challenging':

if we were just taught Zen I would have given up ... almost had a break down at Christmas time last year so I would say about a year and a half into my training ... I was run ragged um and I could feel it, like I was breaking down and I thought I can't ... I literally cannot keep this pace up anymore ok ... I'm not getting on with Zen, I'm not feeling anything so I must be doing something wrong, is this for me? ... I'm exhausted. [Sheila]

Additionally, some participants were 'worried' that their friends might view them as 'flaky' or 'odd', as Shiatsu was outside of mainstream health care, and this concern reflects the continuing theme of differing world views particularly in relation to the status of scientific and non-scientific knowledge.

For example, echoing Natasha's comment that her friends might think she was 'one of the weird people', and reflecting Maggie's concern that Shiatsu was not grounded in scientific thinking and outside of mainstream health care, despite her enthusiasm Nora appeared to be unsettled:

oh God people are gonna really roll their eyes and just like the conversation's gonna change when I start saying 'I'm training to be a Shiatsu practitioner' people are gonna think that I've lost the plot [laugh] because it's not a mainstream thing ... my perception is that it wasn't a mainstream thing you know it. [Nora]

Wariness was also expressed by participants in other ways; for example Maggie wanted to keep 'one foot in the scientific camp of mainstream health'. However, although Maggie had initially resisted her friend's suggestion that she should try Shiatsu due to her scepticism about it at the time, after beginning her training, Maggie reflected how she 'suddenly thought' she could 'feel something' and was 'quite astounded' at how this experience affected her and which made her feel that Shiatsu was 'worthwhile pursuing'. Her experience reflects Leo's sense that a 'door was opening'.

Thus, although students felt initially excited by and embraced the new ideas associated with Shiatsu theory and practice, they also felt confused and challenged by the competing bodies of knowledge, a point further highlighted by Leo's experience as a teacher:

I went round to all the other schools and the first year students ... they were beautiful, their touch was great, the end of the first year ... by the second year they were confused and um insecure and they didn't know what they were meant to be doing. [Leo]

Quality of touch

Although Leo had been one of the instigators of the Shiatsu Society (UK) during the 1980s, he felt that he had 'always been slightly dissatisfied by the theories behind Shiatsu'. Part of Leo's dissatisfaction with Shiatsu theory was how he felt some of it did not make sense and it felt a bit 'shoe-horned in':

it's a bit like one of these maps of the world you try and fit it on the globe and it's got crinkles because it doesn't really fit. [Leo]

Furthermore, he considered the way other people were 'teaching' Shiatsu was not about 'quality of touch' in the way he had been taught at the Aikido class but was about 'routines' and 'techniques' such as telling people to 'come from the hara and things like that'. Leo began to see Shiatsu in a different way to other practitioners and to develop his ideas around Shiatsu. He argued for a different approach and developed a series of classes based on his theory of 'six forms of touch' which focused on the 'relationship you have with somebody not just to do with how you touch them physically'.

Leo felt that the Shiatsu Society baseline syllabus could be 'reformulated to be a proper curriculum with learning outcomes' based on something general like 'being able to manipulate joints in the body' and to be able take the 'six forms of touch' that he had developed during the 1980s as learning outcomes to enable people to be able to 'sense when someone needed deep touch and when someone needed light touch':

when you do a stretch rather than trying to stretch as much as you can you find the boundary of the stretch so you take up the thing and so for the physical side of it is being able to either go in onto a point or to pull with the stretch not to go in as far as you can or to stretch as far as you can but going to the front door and saying 'I'm here' and then waiting for them to let ... to release and to let go so it becomes their choice rather than a surrender to you. [Leo]

Leo felt that if the 'whole Shiatsu training was specified in terms of learning outcomes then a teacher or a school could teach a consistent system' and not 'worry about whether they have brought in the Five Elements or TCM'. He felt this would give a 'feeling of consistency and explanatory power' which would enable people to 'feel that they knew what they were doing'. Thus Leo stands out in how he was seeking to challenge and develop the existing Shiatsu training programme.

Students developing their own style

During their training, students were encouraged to develop their own style of Shiatsu and to many participants this felt rewarding. For example, despite Sheila feeling 'there's still loads to learn', she felt she now had 'all the tools' she needed and that she 'just literally had to put them into practice and not try and learn new theory' but try to 'work with stuff' that she had learned. Sheila's sense was that in her third year her 'personal style was really beginning to start to take over'.

From a Buddhist perspective, Rona felt a Shiatsu session 'is what it needs to be'. Although she felt 'sometimes you can have or you can be taught a certain formula', she did not 'follow suit' and attributed her 'relaxed approach' to her 'own experiences' in receiving 'complementary therapy for a number of years'. It did not matter to Rona if the hour's treatment was '40 minute's conversation and 20 minutes Shiatsu or vice versa'.

Students' experiences of the points at which they felt their learning was transformed and their Shiatsu practice had reached a turning point, appeared to occur most during informal gatherings (support groups) or when practising on each other outside of formally taught sessions. For example, when Rita was a student she felt that 'it was really good' that they 'did quite a lot of work on each other by swapping sessions'. She reflected, that after they had finished the teaching session some of the students in her group would 'stay behind and work on each other'. Rita gave a specific example of how during her training several students had 'got together' at a friend's house over a period of four weeks to explore the meridians:

we had a male friend um who would strip off to his boxer shorts and let us draw on him and we drew the meridians ... we did the Yang meridians one time and the Yin meridians another so then it was ok for him to wash them off [laugh]. [Rita]

Rita felt these experiences were 'such learning curves 'cos you can see the body move and see the way the meridians move and what happens as a result of that'. Furthermore, Rita thought it 'was very interesting to get feedback from 'the male friend' because it helped him understand what he was receiving better'. However, crucially for Rita, she felt that it was valuable to receive feedback from people who had some experience and understanding of Shiatsu.

Similarly, Sheila felt support networks and workshops were 'really good' because they filled a gap if her practice felt 'slightly stale and uninspired and a bit confused'. She also felt that going to Shiatsu Society (UK) Congress was very helpful as it enabled her to learn new techniques as well as reminding her of all that she was learning during her training and also provided the opportunity to work with 'new bodies'.

In contrast, although Anita was aware of the local Shiatsu Support Group and thought it was 'really important', because of public transport problems she had not been able to attend. Her feeling was that in not being able to access 'these spaces', Anita felt she did not 'blossom and develop' her practice in the same way as other students whom she perceived to be so much 'more confident, so much more self-assured and so technically way ahead'.

Students' experiences of developing their own style not only reflects that there is no one style of Shiatsu but also how informal learning spaces appeared to be significant in supporting them to develop their own style.

Concluding comments

Analysis of the data suggested five key themes in relation to participants' journeys of 'Getting into Shiatsu' and which highlighted various turning points and tensions. Participants' wide range of experiences, different trajectories and ways

in which they positioned themselves in their stories reflect the diverse range of participants recruited to this study. I argue this is a particular strength of my thesis.

The first part, 'A voyage of discovery' which focused on participants' exploratory experiences in relation to self-development, discussed how participants positioned their ideas around health and how these related to Shiatsu. Some participants said they had been interested in Shiatsu for most of their adult life. For example, some participants talked about early life experiences and how these were formative in leading them to Shiatsu. These experiences included for example, being curious about food (Sally, Lavinia and Leo) or seeing a picture (Kat, Lavinia, Rona and Natasha). Some early formative experiences remained dormant for several years (for example, seeing a picture). Other experiences appeared to lead directly to Shiatsu (for example, Leo's explorations lead him to Aikido).

The second part, 'Supporting my health' focused on how participants sought ways of supporting their health. Experiences of health-related issues led some participants directly to Shiatsu and to feeling more supported than the care provided by orthodox systems in this respect (for example Natasha's breakdown, Lavinia's bout of hepatitis). In contrast, Sally's early life experiences of health-related issues not only turned her away from orthodox medicine but also led her to feel out of control of her health and consequently spending many years in search of a meaningful way to support her health. Other participants' health-related issues were affecting their ability to work (Anita, Ellen) and saw Shiatsu as the solution to be able to carry on working. Some participants (Rona, Nora, Lavinia and Joan) were dissatisfied with their job which arguably was affecting

their health. Thus, health-related issues were important in motivating participants toward Shiatsu.

In the overall trajectory of 'Getting into Shiatsu', the third part, 'From supporting oneself to supporting the health of others', highlighted a turning point reflecting how some participants (Leo, Madelaine, Joan, Ellen, Nora) began to think about how they would like to use Shiatsu to support the health of other people.

Meaningful engagements with other ways of thinking about their health is predominantly illustrated through experiences of participating in retreats where some participants encountered the ideas and philosophy underpinning traditional Eastern ways of approaching health. Often it was through these events that participants, for example Nora and Ellen, experienced Shiatsu for the first time and found these experiences very empowering. The ideas behind Shiatsu seemed to make sense to them on both a spiritual and physical level and chime with their approach to health. Specifically, some participants (Nora, Natasha and Olivia) saw Shiatsu as a meaningful way to link body and mind and saw that this was how 'East meets West'. Many participants were influenced by people already trained in Shiatsu and this was not only a significant motivating force to train in Shiatsu but also led some participants to consider a career change highlighting a significant turning point in their life.

The fourth part, 'Seeking Shiatsu as a qualification' indicated a further turning point relating to the ways in which participants sought a qualification in Shiatsu. It began by considering the training trajectories of more long-standing practitioners (Leo, Madelaine, Lavinia) and then examined the more recent experiences of participants in relation to the choices and motivations around decisions to train in Shiatsu. In contrast to those participants who had experienced Shiatsu and how this had inspired them to train, some participants described their experiences and

how these led to Shiatsu in more pragmatic terms. Predominantly these experiences were related to earning a living. For some participants it had become necessary to change their jobs – for example Maggie and Anita who saw Shiatsu as a means of earning a living. On the one hand these experiences highlight turning points in respect of a change of direction in participants' work. On the other hand, in some cases the aim was to include Shiatsu as an addition to their repertoire of existing therapies (Rita, Megan, Olivia). Some participants were undecided initially between choosing Shiatsu or another therapy which, in some cases, (Anita, Kat, Rona, Sheila) reflected that Shiatsu was not the specific attraction in the first instance.

Although the ideas underpinning the philosophy and experiences of Shiatsu appeared to be the significant determinant in drawing participants to Shiatsu, sometimes friends or relations influenced participants' choice of direction in relation to Shiatsu. Sometimes, participants positioned others in their accounts to justify their decisions.

The final part, 'Shiatsu training – a vast toolbox' highlighted the differing and often competing bodies of knowledge included in the Shiatsu training programme and exposed a key challenge experienced by students in this respect. On the one hand, some participants were excited and drawn to the ideas of Shiatsu, while on the other hand they were confused by the uneasy fit of the different kinds of knowledge. A key turning point for students occurred when they began to develop their own style of Shiatsu and when their learning was most transformed by the informal spaces. It also highlighted a proposal by the most long-standing participant – Leo – in respect of his ideas around how to reform the Shiatsu training programme toward a focus on 'quality of touch'.

Two key tensions are highlighted by participants' experiences: first a tension between different approaches to health – essentially Western medicine and traditions originating from the East. At the same time, participants are seeing Shiatsu as a means of joining Eastern and Western ways of approaching health and particularly in relation to linking mind and body in respect of mental health. In extreme, as highlighted in Chapter 2, this tension is exposed through different kinds of knowledge represented by scientific and non-scientific knowledge. A second tension stems from issues around work and the ways in which participants seek ways to earn a living, particularly in relation to earning a living meaningfully. These tensions will be discussed further in the final chapter.

Thus, this chapter has examined participants' experiences in relation to what drew them to Shiatsu. Their experiences highlight several influences associated with health- and work-related issues and that participants are at different stages in their life course. It has begun to highlight some potential issues in relation to 'getting out there to practise Shiatsu', particularly for example, the challenges of earning a living through Shiatsu and how participants position and explain their practice.

The next chapter, 'Getting out there to practise Shiatsu', continues the trajectory of participants' pathways to practice. It takes forward these two tensions by examining the different ways in which participants practised Shiatsu.

CHAPTER 5

Getting out there to practise Shiatsu

Introduction

This chapter is in three parts reflecting the key themes in the trajectory of 'Getting out there to practise Shiatsu'. First, the chapter focuses on the different ways participants identified and positioned their practice, beginning with how students imagined they would be practising Shiatsu once they had qualified. As in the preceding chapter, the themes identified in this part of the trajectory are not clear-cut highlighting the complexity of participants' practice. The chapter then focuses on the challenges facing participants in private practice, highlighting a particular turning point in relation to setting up in business and earning a living solely by Shiatsu in this way. The final part examines the ways in which participants explained their Shiatsu practice.

The chapter exposes a number of challenges, turning points and tensions experienced by all groups and particularly brings into focus the tensions associated with practising Shiatsu in mainstream health care, picking up on the themes and tensions from the preceding chapter.

Part 1 Positioning their practice

Despite some overlapping, analysis of the participants' descriptions suggested broadly three kinds of ways in which participants practised Shiatsu and which reflected students' imagined trajectories into practice.

The largest group of qualified participants identified themselves as 'Shiatsu practitioners' even though they might practise one or more other therapies. This group comprised both relatively newly qualified and more experienced

participants. Some more experienced participants in this group also taught Shiatsu. Some participants in this group earned a living solely through practising Shiatsu, whereas other participants supplemented their income through other paid work.

A second group comprising two participants saw themselves more as 'multi-therapists' or 'CAM practitioners' in that they practised Shiatsu as part of a suite of other complementary therapies. In this sense, to use a phrase from the previous chapter in relation to motivation for signing up for Shiatsu training, they were using Shiatsu as a means of 'broadening their therapy belts' and thus this group is distinctive in this sense.

Two participants practised Shiatsu within NHS mental health settings and I identified this as a third group, although it is not completely distinct from the first group in the sense that these two practitioners felt they had identities as Shiatsu practitioners within the NHS setting. However, this group is distinctive on account of the particular setting, highlighting the challenge of practising Shiatsu within a NHS setting.

Students' imagined trajectories into practice

In looking forward, although not all students were sure that they would pursue Shiatsu in a 'business way' (make a living by charging), as highlighted in the previous chapter, most had some kind of long-term plans. Thus, students appeared to be cautiously optimistic about future plans to practise Shiatsu, generally reflecting Rona's pragmatic view that 'some of us will end up in environments because actually we need to or we need to pay the bills'.

Nora was 'toying with the idea' of doing a counselling qualification alongside Shiatsu because she felt that bodywork can bring out different emotional issues

and it might be useful to be able to explore those in 'a professional way' with the person. She perceived this combination as enabling her to offer 'a really holistic kind of approach'. Nora explained that she did not want her practice to 'feel fragmented' by 'dabbling in this and dabbling in that'. She wanted to 'kind of like hone things in' so that she had 'more of a specific direction in which Shiatsu's gonna be part of that direction'.

Like Nora, Rona was 'not sure that it'll be sort of pure Shiatsu' and was also clear that she wanted a 'few more tools under my belt to just be a bit more flexible'. She wanted to develop 'the acupuncture side and counselling skills' although she did not 'feel the desire to have a psychology degree or anything like that or counselling qualification'.

Anita, who was also studying Hypnotherapy, realised she was not only enjoying the Hypnotherapy training but also admitted 'it comes more easily to me than Shiatsu'. Despite some reservations as to whether she would pursue Shiatsu, Anita felt that 'the two will complement each other in the end' and was hoping she would be able to develop the two therapies into 'my sort of earning a living'. If this was not possible, she felt she would like to 'keep up the Shiatsu somehow even if it was only with family or friends' as she found it 'sufficiently interesting' and felt it was 'nice' to see the effect it had on people.

Sheila felt she would 'love' to work for a big organisation because there are 'policies and procedures and teams already set up' and 'what we do can be quite lonely' so this structure would give her the 'support to work within'. However, Sheila felt that she might 'outgrow a place or they outgrow you' and if she 'couldn't challenge them', she felt she would 'move on' rather than go into business for herself because that's 'quite daunting'. Although Sheila would 'love

to believe' that she could get the 'job of her dreams doing Shiatsu', she felt that realistically this was not likely to happen:

so so it's retaining that optimism but also realising that you're not gonna walk out with a [qualification] and someone's gonna go 'Shiatsu that's wonderful come and work for us'. [Sheila]

Kat was also keen to explore possibilities of joining other organisations, for example she wanted to 'go into schools and treat teachers' and 'do days in businesses'. She also wanted to 'work with soldiers coming back from war and all sorts of different areas'. However, like Sheila, she also 'knew' that this was not going to 'happen straight away'.

Some students expressed greater certainty than others about setting up a business to practise Shiatsu. Of the two students who were in their first and second years of training, both indicated they intended to do so. For example, Nora indicated she was thinking 'along the lines' of setting up her own business as a Shiatsu practitioner. Similarly, Rona 'definitely' wanted to go into 'private practice'.

On the other hand, as indicated above, going into business had never been Sheila's 'ideal' or 'even a thought' in her head. Although, Anita indicated that she was hoping to earn a living in some way, she felt that Shiatsu had always been her 'plan Z' and was questioning whether she 'loved it enough' to keep on with it. Anita perceived herself to be 'fairly ancient' and that she may not have 'the 20 years' to develop Shiatsu and one of her concerns, reflecting the physical demands of Shiatsu, was 'how many years are my knees going to last?'.

Also in their third year but in their early 20s and therefore considerably younger than other participants, Doris and Megan's plans were yet to crystallise. Megan's 'long-term goal' was to set up a 'spa centre thing' and include all different 'health

things' like Yoga and Shiatsu and 'basically anything that affects the body'.

Although Megan did not specifically mention whether or not she intended to set up a business, this was perhaps implicitly part of her long-term goal.

Doris, was 'really hesitant to have a job and go into work full-time'. Her aim was 'just to get people to know about Shiatsu even if it's just a one-off treatment'. She wanted to pursue Shiatsu but did not know if she wanted to continue it in a 'business type of way'. Doris felt that to pursue Shiatsu in a 'business way' would put pressure on her to earn money through Shiatsu and 'that would take the enjoyment out of Shiatsu' and she did not 'ever want to feel like Shiatsu is a chore'. Despite her reservations about earning money through Shiatsu, Doris mentioned longer-term plans which involved working with adolescents and teenagers and which arguably might develop into a more of a business-type of venture.

Kat, also in her early 20s, had just graduated and did not have a job. Although she had started her training not knowing what she would do when she finished and her 'motto' was 'just to see how it goes', she had a 'wake-up call' as she now 'needed to start earning a living'.

Inspired by a conversation with a plumber (who was the partner of one of her clients), Kat decided to set up her own business. Pivotal to her decision was the plumber's advice:

you'll be getting up at half past seven in the morning to go to work anyway you might as well do it while you're self-employed 'cos you're gonna do it anyway whether you work for someone or not'. [Kat]

Although Kat felt that 'sort of dipping into this unknown territory' of being self-employed was 'scary' because she was 'young', she felt prepared to 'work really

hard', and despite her reservations she indicated that 'tomorrow she was going to be registered as self-employed'.

In contrast to her contemporaries, Doris and Megan, Kat was very explicit about needing to 'make a living' and therefore knew that she 'would not only need to charge but also get as many clients as possible'. Kat's perception was that 'there's a lot of older people in their 30s, 40s and 50s who do Shiatsu' and she felt it would be helpful in the 'long run of getting Shiatsu out there' if 'somebody new and fresh and younger' could be 'brought in to do stuff like this'. She felt that 'sometimes people are a bit wary of Shiatsu because it's a really old sort of healing'. However, she also felt that Shiatsu might have more appeal than other forms of complementary therapies and she wanted to distinguish it from other complementary therapies like Aromatherapy because she felt that 'men would not go for Aromatherapy'. Kat's plan was to set up her website and bring Shiatsu 'into the 21st century' and she aimed to achieve this with help from her brother who 'does websites in his spare time'. At the time of interview, she was in the process of 'putting together a leaflet' and had prepared business cards and had a Facebook page.

Most students reflected Nora's view that 'Shiatsu has something that it can offer that complements Western medicine and it's like an East meets West kind of thing'. For example, Sheila perceived Shiatsu as 'very versatile' and that this gave it potential for 'working really well within teams'. Sheila could envisage a situation – particularly in a clinical setting – where as a practitioner, she could 'kind of slide in and fit in anywhere because Shiatsu is more than just one thing'.

Despite the general perception that there was a lack of opportunities in relation to the NHS, some students were optimistically considering the possibility of working for the NHS. For example, Doris' GP practice had suggested she get in touch

once she had finished her training and Doris indicated she was 'thinking of going to her local GP back home' to follow up on a conversation where they had discussed Doris doing some voluntary work using Shiatsu. Rona was particularly keen to try and get a placement in a menopause clinic within the NHS. Furthermore, she thought that if the NHS had roles available (as a paid employee) then she 'would have no problem working within the NHS' but her perception was that the roles did not exist.

Thus, most students wanted to pursue Shiatsu and make a living to some extent. Some were more definite that they would like to set up a business and not all were intent on charging, some preferring to practise Shiatsu on a voluntary basis (for example, Doris). Most had long-term plans and were considering combining Shiatsu with another therapy or therapies, perceiving the combination to be complementary to the Shiatsu bodywork and offering a holistic approach. Joining an existing organisation, whether the NHS or private business, was mentioned by several participants. As illustrated in Sheila's quote above, student participants were under no illusion that 'getting out there to practise Shiatsu' and earning a living was going to be easy.

This chapter now considers the ways in which qualified participant practitioners positioned their Shiatsu practice. As outlined at the beginning of this part, analysis of participants' accounts suggested that qualified practitioners could be divided into the three groups outlined. These included: (1) participants who identified themselves as *Shiatsu practitioners*, (2) participants who identified themselves as multi-therapists or *CAM practitioners* and (3) participants who identified themselves as *Shiatsu practitioners practising Shiatsu within the NHS*.

Shiatsu practitioners

This part considers participants who appeared to identify themselves primarily as Shiatsu practitioners as distinct from 'CAM practitioners'. As mentioned earlier, these participants formed the largest group and included both relatively newly qualified as well as more experienced practitioners. Some participants in this group earned their living solely through Shiatsu whereas others supplemented their income through other paid work.

The following section considers those participants in this group who were supplementing their Shiatsu income through other paid work.

Running their own clinics and doing other paid work

Stephanie and Ellen were both cautiously hanging onto their paid work for three days a week and which they still perceived to be their 'main job'. They enjoyed their 'main jobs' but Stephanie was more certain than Ellen about her long-term objectives for Shiatsu. Ellen reflected that she had been doing Shiatsu because she felt it supported her health as it felt like a 'really healthy thing to do'.

However, although Ellen felt that Shiatsu was helping her become more confident in her main job, there were some opportunities 'bubbling up' associated with her job and she was considering giving up Shiatsu. On the other hand Stephanie considered that her 'objective now was to build up a decent client-base, decent practice with one or two days a week'.

A key issue for many participants was that despite finding Shiatsu rewarding and wanting to earn a living as a practitioner, they faced the challenge of reaching the point where they generated sufficient income through Shiatsu to be able to let go of their other paid work. For example, although Stephanie felt that people were always pleased to see her because she was 'going to give them a nice experience' and how she enjoyed the contrast to her sedentary job, she did not

think she would be able to practice Shiatsu on a full-time basis due to her financial commitments:

it doesn't pay nearly enough to meet my financial commitment like a mortgage so I'd still have to keep going with my day job for a few years um but ... maybe when I'm retired [laughs]. [Stephanie]

Furthermore, she explained that although it would be nice to be able to practise Shiatsu a few days a week, she might 'have to switch back at any time' to four or five days a week in her 'normal day job'.

Stephanie's intention was to see how much she could make 'just for this year to see if it's worth pursuing':

'cos if it isn't it will be just a hobby really ... not a job as such. [Stephanie]

As previously discussed, Sally's main reason for taking up Shiatsu was because she wanted to be 'in control' of her body and also support the health of others in this way. Toward the end of her training and reflecting other participants' accounts, she wanted to fulfil her 'dream' of practising Shiatsu two days a week and run her computer business for the other three days. Although ten years after completing her training, Sally had achieved her ambition of 'running her own little clinic³⁴', she felt dissatisfied that 'it never really worked out' in the way she had envisaged. She explained this was because it was taking too much of her time 'pushing' or marketing Shiatsu:

I'm not satisfied in that I've not expanded it and it's not growing and it's um I've tried efforts at marketing and so on but um and I've had little spurts you know and I'll get groups in and I'll have good month and then you know they'll all be happy and go away and um don't come to me for a while until something crops up again for a while I haven't quite got that continuity that others have um but um then of course I added the Acupuncture on to it. [Sally]

³⁴ Please see Appendix 1- Joan and Sally's Shiatsu spaces

Sally felt she had to put all her 'energy into' her 'projects' from her computer business in order to keep that side of things going. She also felt she 'was trying to do too much' and frustrated that despite having 'these business skills' to run her computer business, she did not know how to run her own 'Shiatsu business'.

Letting go of the day job

Madelaine's account illustrates how she transitioned to earning her living through practising and teaching Shiatsu on a full-time basis, highlighting a key turning point in respect of private practice.

During the 1980s, Madelaine was practising a 'little Shiatsu' and also working part-time in a healthfood shop to support herself because the money generated through Shiatsu alone was 'insufficient to make a living'. Although she 'wasn't expecting Shiatsu to turn into a career' when she undertook her training during the early 1980s, Madelaine's intention was to gradually begin to 'cut down' her work in the healthfood shop so that she could 'do more Shiatsu'. Although she felt 'very fortunate' that she was in the sort of job that enabled her to gradually reduce her hours, it was a difficult decision finally to let go of her part-time work which represented letting go of the 'safety of definitely earning that money'. However, Madelaine felt that unless she let go of her part-time work in the healthfood shop, she could not expand her Shiatsu practice:

I just remember hearing myself handing in my resignation [laughs] and it was like I was behind myself listening to me resigning thinking but I don't have enough for my Shiatsu to survive [laughs] so it was like sitting it out and it was almost like I had to let go of that job in order to have enough time and space to earn more from the Shiatsu. [Madelaine]

Madelaine also experienced being in the position of supporting her Shiatsu practice through other paid work when she first started to practise Shiatsu during the 1980s. She felt that it was a 'specific skill to be self-employed and some

people can't deal with working on their own'. She supposed that some people would find it a 'big challenge to give up a fairly well paid job' because to 'get their Shiatsu income up to a reasonable level, it would take a time'. Madelaine felt there was a need to support practitioners in becoming self-employed because:

it's easy when money just pops into your bank account at the end of the month ... but to have to ask someone to give you cash in hand is a lot harder for some people ... you've got to have a clear idea of the value of your services ... [Madelaine]

Madelaine's concern was that she felt people were 'far too ready' to say 'Well if that's too much you could perhaps pay me a bit less'. She felt that it was 'no good setting a price if you were going to offer a discount to everybody'. Nonetheless, Madelaine felt one of the challenges was that 'your income is never guaranteed and 'it's having that trust that you will be earning enough'.

Wobbly moments and support

Despite her success in achieving her ambition of working as a Shiatsu practitioner within the NHS, Natasha 'certainly did have some wobbly moments' when she questioned herself about what she was doing and whether she was opting out of living a 'proper life' by wanting to do this 'strange thing'.

Natasha felt that 'what kept her going' in those wobbly moments were her 'fellow practitioners, her own experiences and knowing what they were working with was a real genuine support for people'. She felt it was 'good medicine' for her working as a practitioner and what kept her going was 'being intellectually very curious' about the 'thousands of years of the body of Chinese medicine and how different practitioners are orientated in different ways'.

Coping with the number of treatments in one day

Part of the challenge to generate sufficient income to have a viable practice also meant undertaking a minimum number of treatments within any one day.

Achieving and maintaining this quantity of treatments also involved being able to cope physically. During their second year of training, students were expected to perform a set number of regular treatments, which often meant an increase in the number they had been used to doing in their first year. The significance of being able to achieve this increase had direct implications for running a viable practice. However, for some students this felt like 'pressure'. For example, Doris felt that in her first year it did not matter 'how many treatments you do as long as you're doing some kind of practice' but that in the second year 'having to do more treatments was an issue' because she was doing Shiatsu because she 'had to' rather than because she 'wanted to'. For some participants, there was the additional challenge of ensuring they were sufficiently fit to be able to practise the required number of treatments.

Many participants practised Yoga or Tai Chi as a means of keeping physically well. They also attended regular Shiatsu practice classes, not only to develop their practice but also to learn physical exercises to support their health (for example, the Makko-ho stretches mentioned in Chapter 2). Nonetheless, maintaining a level of fitness was an issue as illustrated by Anita's comment on whether her 'knees would last'.

The greatest number of treatments Stephanie had done in one day amounted to four but she felt this 'wasn't too terrible' as they were 'quite spread out'. In a 'bad month', Sally might have two clients and in a 'good month' she could have up to 16 clients. Sally felt her 'mistake was just saying to people come anytime' and lately she had 'begun to focus it down on to two days and try and get a full diary on those full days'. She had not 'got a full diary by any means' although some days she had reached the 'heady figure of five' clients. However, Sally was

concerned that she did not know whether that was a 'good number' and how it compared to other practitioners.

Working from home and trimming her cloth

In contrast to practitioners who were doing other paid work to support their Shiatsu practice, Maggie's 'sole job' (apart from Tai Chi teaching 'which comes and goes') was practising Shiatsu which she had been doing 'for almost twice as long' as any other job. Maggie had 'no expectations at the time' of her Shiatsu training and 'did the training not even thinking' she was going to be a Shiatsu practitioner. As discussed, Maggie's decision to train was a pragmatic choice following her redundancy and based on how she was clear that she was not going to return to the 'same line of work'. Following her training, Maggie 'decided the proper job was hard work and Shiatsu was far more important':

um and so I jacked the proper job in and I've been a Shiatsu practitioner ever since which is over a decade. [Maggie]

She was 'quite astounded' at how Shiatsu had changed her 'attitude to life generally'. However, Maggie did not have 'vast bills' to pay and could 'trim her cloth to suit' according to what she 'had coming in'. She was 'not all that enthusiastic about working all the hours that God sends' as she envisaged that she would retire within a couple of years. Unlike Sally who was dissatisfied with how her Shiatsu business was going, Maggie's view was she wanted to 'enjoy' herself and so that is what she was 'doing at the moment'. She felt that physically she needed to move from her current location because it was a 'very damp part of the world and she was getting arthritis'. As such, while she 'loved doing Shiatsu' and would continue to practise 'while the body was still working', she also 'liked travelling' and looked forward to 'getting out there in her camper van and just be totally self-indulgent instead of only partly self-indulgent'.

Thus unlike other participants in this study who were seeking to expand their practice, Maggie appeared to have reached a point in her life course where she was earning sufficient money through Shiatsu to support herself for a further two years before she retired.

Becoming a Shiatsu teacher

Lavinia earned her living through Shiatsu, practising both from home in a medium-sized town as well as in another nearby town where she rented a room. She had built up her practice over the course of about 25 years and now had reached the point whereby she had a 'thriving' practice. Like other long-standing participants – Leo, Natasha and Madelaine – she also taught Shiatsu to support her Shiatsu income. Lavinia taught Shiatsu in various locations, including Shiatsu training schools and a university setting, and also led various practice classes and weekend training sessions. Her account illustrates how she became a Shiatsu teacher not only because she enjoyed teaching but also as a way of enhancing and enriching her general Shiatsu practice. Her account also highlights continuing resistance to teaching CAM as part of the Higher Education (HE) sector.

Following the completion of her training, Lavinia practised Shiatsu 'from an Acupuncture clinic' in a rural setting in the north of England. She felt that 'Acupuncture was so accepted in that whole area' that this helped Shiatsu to become accepted. She 'gave a few talks and very soon had quite a busy practice' and would have 'expanded it more' but she 'had to put things on hold for a bit' as 'the children had arrived'. Following the arrival of her children, Lavinia wondered whether she would 'take up Shiatsu again'. However, she reflected, that 'it just so happened' that one or two of her clients rang up seeking a Shiatsu treatment and then she 'just got the thread' again.

After moving south, Lavinia continued 'building up a practice' and was invited to assist³⁵ at a local training venue on monthly basis. On beginning this role, Lavinia found that all the teachers were 'big names' but when she 'chatted with them', she realised that they 'actually often had less Shiatsu experience' than she did:

when they knew what I'd done and where I'd trained and they said 'Well why don't you teach?, you know, you could teach' and so I started doing er teacher training ... I ... it was difficult for me because I wasn't with a school so I had to set up supervisors um and it was ... it was really good and um I got my teaching ... it happened quite quickly and immediately.
[Lavinia]

Lavinia became a teacher in 1998 and 'loved teaching'. She thought that if she had not done Shiatsu teaching she would 'probably have gone into teaching'. Lavinia saw teaching as 'sharing' and valued the 'wealth of experience' that students bring and thought this was something that should be 'tapped'. Shortly after becoming a Shiatsu teacher, Lavinia accepted an invitation to teach Shiatsu at a university as part of a degree in complementary therapies.

When I spoke with Lavinia, the course had been running for about 10 years but was due to finish within the next year. Lavinia 'was not quite sure why Shiatsu was being extinguished' because the 'teachers won prizes for their teaching and the feedback from external moderation was top'. She thought that the 'person high up had made the decision because they did not believe in complementary therapies at all'. The phasing out of the course not only reflects an increasing squeeze on universities' funds in respect of cut-backs in higher education funding (BIS 2011) but also perhaps in this instance, a response to pressure from critics, for example Ernst (2008), of universities providing Bachelor of Science degrees in subjects not perceived to be science.

³⁵ 'Assist' as the name suggests, involved assisting the main teacher during Shiatsu training. Assistants were often people who were seeking or undergoing teacher training.

She had been 'very excited to have been involved with it' and felt that it had been 'switched off' just when it was about to come to its 'important stage'. However, in respect of earning a living, Lavinia was not concerned about her involvement with the university course coming to an end as she felt that she was 'busy enough' and did not need the teaching income. She saw this as 'providing a space for other things to happen'.

CAM practitioners – using Shiatsu to broaden their therapy belts

The distinctive feature of this group is how these participants were integrating Shiatsu into their existing practices and reflects several students' intentions to practise other therapies alongside Shiatsu. As previously indicated, the boundaries between all three groups are blurred in various ways. For example, in respect of this group, although some participants practised other therapies (for example, Sally practised Acupuncture alongside Shiatsu), this group of participants saw themselves more as 'multi-therapists' or 'complementary practitioners' rather than purely 'Shiatsu practitioners'.

A further example of how the distinctions between these groups are not necessarily clear-cut is how some participants sought to train in other therapies as a means of self-development. Some participants felt they wanted to have some training in counselling to support their own practice. For example, Leo found that sometimes working with clients 'brought up emotional stuff' for him which he 'found really difficult to deal with' and so started 'doing psychotherapy training to get the self-knowledge' to learn about 'other people's emotions'. He described the psychotherapy training as an 'apprenticeship system' as he 'wasn't doing it to be a therapist' but was doing it 'as self-development'.

Joan and Rita were both seeking to integrate Shiatsu into their existing respective set of complementary practices. Neither Joan nor Rita held any other kind of paid work outside their complementary therapy practices. However, Joan was mainly practising on a voluntary basis at a Cancer Care Centre as she felt she did not need to earn money – at least for the time being:

I'm not you know Mrs loads of money but I can actually afford not to work for a little while and so that's what I'm doing' and I'm happy with that.
[Joan]

On the other hand, Rita indicated her intention to continue to earn a living by broadening her 'complementary therapy practice' and integrating Shiatsu. She described herself as 'quite eclectic' as she practised many therapies and did not feel there were 'crystal clear boundaries' between Shiatsu and some of her other therapies. Furthermore, Rita felt it was important not to put Shiatsu on a 'pedestal' because other therapies are 'just different tools'. Her feeling was that therapists should 'refer to each other and respect each other and not diss each other'. Rita had created a dedicated space within her home and had set it up such that she could practise all her therapies from there. Rita also had a website and this appeared to be her main way of marketing herself as a 'multi-therapist'. She often worked evenings and weekends practising her therapies and also taught other therapies and ran different workshops using these events to promote her practise.

Shiatsu practitioners within the NHS

In contrast to the participants discussed earlier, two participants – Olivia and Natasha – saw themselves as Shiatsu practitioners working within the NHS. These accounts illustrate the process by which Shiatsu, as a distinct healthcare practice which normally sits outside of mainstream health care, was integrated in mainstream health care in two NHS mental health settings. Olivia's account

illustrates how, from her existing position as an employee within the NHS, she succeeded in gaining an identity as a Shiatsu practitioner. On the other hand, Natasha's account illustrates how, from her position outside the NHS, she gained access to become employed on a consultancy basis as a Shiatsu practitioner within the NHS. In contrast to those in private practice who charged a fee, the patients or service users who came for Shiatsu in the NHS did not pay any money. Olivia and Natasha's accounts show how issues around being trusted and being seen to act professionally were important in the process of becoming accepted.

Sliding in – knowing what was expected and being trusted

Olivia was employed part-time by an NHS hospital working 19 hours a week as a 'Support Time and Recovery Worker'. She described how she was part of a team that offered a 'kind of a community service involving lots of support from lots of different areas'. She felt 'it actually really works well as a team':

I'm a part of that [the team] um so we do employment support, volunteering, education, the social groups, exercise groups, art groups, all sorts ... all sorts of different thing. [Olivia]

She was also self-employed working six hours a week for a Framework Housing Association as part of a team supporting 'people with mental health problems' who were living in a hostel.

As discussed in the last chapter, Olivia felt she had been 'in the right place at the right time' as an employee of the hospital, to be part-funded to train in Shiatsu. Other colleagues had similarly taken the opportunity to train in other therapies such as Indian Head Massage.

Reflecting Sheila's notion of being able to 'slide in' to an organisation to practise Shiatsu, Olivia felt it was only by using her existing position and relationships with

colleagues as an employee at the hospital, that she had 'kind of got in by the back door to practise Shiatsu and her other therapies'. However, more specifically, she attributed her 'success' in this respect to her 'proactive' and 'instigatory involvement' in developing and 'pushing for the safe practice policy'.

For example, from her existing position as 'Support Time and Recovery Worker', Olivia was 'doing some healthier eating recommendations with people and kind of exercise type groups and supporting people to go and see physiotherapists'. It was through this work that she 'made friends with the senior physio at the hospital' and together they developed a 'safe and air-tight and professional looking practice procedure policy'. When setting up the policy, Olivia was 'very very careful to ensure that it was very risk assessed and safe' from everyone's perspective and worked hard to ensure that nobody could 'pick holes' in the practice procedure.

Olivia felt it was only in the last three years that she had actually been able to use Shiatsu and had achieved this by 'really sticking at it', because she really 'wanted to' and 'could see it made a difference'. Furthermore, Olivia felt she had created 'a bit of a niche' with what she was doing and saw herself in a 'supervisory role' in not only providing support for people who were 'qualified in different therapies to actually offer it for service users' but noting that they also now 'had a team of people' in this respect. Olivia felt she had 'been supporting other staff to utilise their skills because after the policy was implemented and people had trained in various therapies, they were only 'kind of patchily used' within the Trust. Olivia's observation was that the different therapies (for example, Indian Head Massage) 'had been taken up in some areas and not in others' and there were some people that had not practised for at least 18 months since training. Her strategy for supporting people was to encourage them to do short treatments:

so like for example with the Indian Head Massage um it's normally a 45-minute treatment ... with the treatments I do I get it down to 10 or 15 minutes um so it's manageable in their day it's not a huge chunk of the day ... doesn't take too much energy to do it ... they can combine it with other things and then also make it a lot more available for service users.
[Olivia]

However, in her work at the hospital Olivia felt she 'tended to work over and above her banding'. She was not 'medically qualified and on quite a poor banding'. She felt resentful about not being well-paid and felt under-valued. Despite her dissatisfaction regarding her pay, Olivia felt she had 'an identity as a Shiatsu practitioner' as part of these teams. She attributed this to being 'known and trusted' and also 'knowing the system' and how to 'act professionally'. For example, Olivia 'supposed that having worked in the NHS for so long she had a kind of NHS view' of what it meant to act professionally from within the NHS. She was 'really careful to be seen as being professional' when she worked with service users and particularly 'being viewed by the medical profession'.

Reflecting some other participants' concerns about being perceived as 'flaky', Olivia was 'very aware that a lot of therapies could be seen as being very kind of ethereal' and was wary about 'getting into too much discussion' in this respect. Aware that colleagues would be watching her, Olivia was very careful with how she 'worked with people' and how she 'worded things and tended to keep it very body-based'.

In Olivia's experience, working within the NHS, she felt she was trusted and this was reflected in her feeling that she was beginning to receive some 'really interesting referrals' and she felt that she was 'trusted' to know what she was doing with really quite complex health issues'. Olivia felt she was 'very busy and very included in her teams' and was given 'referrals from anybody who was in need of secondary mental health services'. These referrals included 'people who

were in residential units or living on their own in the community or who may be in one of the hospital beds’.

In accordance with the safe practice policy she had helped to develop, when working with service users, Olivia would ‘always write to the consultant psychiatrist’ and although she felt it was ‘almost like consent’, she also felt she gained a feeling of ‘team working’. However, consultants varied in how they responded to her; some responded in terse terms whereas others would engage, acknowledging that Shiatsu would be very helpful.

Olivia valued how she had ‘quite a lot of autonomy’ in how she structured her time and what therapies she used with people. She was based in an office within the hospital building but she was not tied to a building and had flexibility in where she worked. For example, she could work on the residential units, wards and in a clinic. She worked ‘very closely’ with the Occupational Therapy (OT) department and found them very supportive. Patients were usually escorted to one of the OT rooms and Olivia would do ‘head and shoulders’ Shiatsu on these patients.

Olivia also went ‘regularly’ to the wards and felt that she ‘really saw the benefits’ of Shiatsu on people who were very ‘agitated and really keyed up or feeling a bit aggressive’:

being able to really really being able to calm down and ground themselves and centre themselves as well as people who are incredibly withdrawn, really depressed, really not interested in doing anything, nothing works for them ... you know um to just being completely lifted up out of that um you know with the use of Shiatsu. [Olivia]

Olivia was ‘never invited to reviews and things like that’ and she thought she ‘would like to be more involved in the multi-disciplinary team and be really seen as a part of a person’s recovery journey’. However, she felt that not being invited to reviews was ‘reflective of larger kind of issues within the NHS’ and how there

were 'sort of very separate pockets of teams' because 'other people on her team did not get invited to reviews'.

Endless knocking on doors

In contrast to Olivia's experience of using her 'knowledge of how the NHS works' from her existing position within the NHS, as an 'outsider' Natasha found it was very difficult to work out 'what the hell's going on and who was in charge of what and who to approach, how to begin'. Whereas her 'insider' status led Olivia to feel that she had 'got in by the back door', Natasha had 'got into NHS work through endless knocking on doors' from the outside. She found it very difficult to know who to contact because people change jobs, policy changes as well as the structure of the NHS.

Natasha's experience was that she 'just happened to be in the right place at the right time when there was a little bit of excess budget'. She thought that in being accepted, it was often a case of being perceived as a person who 'looks like they know what they're doing'.

Natasha's experience in this respect is echoed by Leo's experience of working with GPs who were friends – one of whom had learned Shiatsu through Leo's training school. These GPs used to refer at least two or three people a week to Leo. After Leo left London, the doctors no longer referred their patients to 'Shiatsu people' and when Leo questioned why this was the case, they explained:

'Well you ... we knew you and we knew that whatever you did was good but it's not Shiatsu necessarily it's 'cos it was you that was good'. [Leo]

Leo commented that the doctors said they received 'requests from dozens of alternative therapists to be part of their practice and be referred'. However, they did not recruit therapists or refer because 'they had not got a clue which to go for'

because (reflecting Natasha's experience) 'really it's to do with the person rather than to do with the therapy'.

Echoing Olivia's experience when 'knocking on the door', Natasha felt she had had to 'think very practically' and 'be pretty focused on being in tune and aware of what policies' aligned with her 'project proposals' and what was 'relevant and fitting' by way of what Shiatsu could offer in relation to an 'unmet need within the system'. Her perception was that 'when the doors were ready to open', it was not a 'case of needing to convince people' and she did not recall anyone ever 'asking to check the evidence base in relation to Shiatsu' or get in touch with the Shiatsu Society:

my experience is when people have the budget and they like you and you have a proper CV and track record and insurance even if it's not exactly in that particular environment they're happy. [Natasha]

Reflecting Olivia's positive experience of working with occupational therapists and physiotherapists, Natasha felt that the 'OT departments had been fantastic' and very good to be aligned with because they were very focused in looking at 'what's working with people and developing people's strengths and not being completely obsessed with pathology and medication'.

Although Olivia felt she had an identity as a Shiatsu practitioner, this was gained both through and within her formal role. In contrast, Natasha felt she had an 'overt identity as a Shiatsu practitioner within the team she worked with in the hospital system'. Despite having this identity, Natasha also recognised the need to be careful to fit in with existing policies and practices and felt that 'one was always aware as an alternative practitioner of wanting to be part of the solution as opposed to part of the problem'. Although she now felt more relaxed than when

she first started, it was quite challenging adjusting to how to work in a hospital environment.

Although she was careful to ensure that she worked within the practices and policies of the hospital, Natasha felt it was 'very liberating and very free being a Shiatsu practitioner because no one can measure you':

and say 'No no no ... I think you shouldn't have been working Heart Protector ... it's obvious that person was so Kidney depleted' you know 'cos they don't know so it's funny you do actually have a lot of freedom within the situation um and you kind of define what your aims and outcomes and objectives are with each individual person. [Natasha]

Her perception was that the team of people she worked with 'were open minded and pleased to get another perspective' and usually when she talked to people about her Shiatsu diagnosis she felt that people felt it 'added to the overview of a particular patient'.

Natasha commented that at one time her notes were not included on the hospital system but that had now changed, although she felt her notes were not necessarily always read by the team. Sometimes Natasha was asked to 'write bits for people's tribunals'. She explained that in her notes she would include information about 'how the person was presenting, whether there were any major risks or issues in that person's life at that moment' and she also included a 'thumbnail' of Shiatsu-specific notes.

The people who came for Shiatsu

Natasha mainly 'saw inpatients and people who were in crisis, homecare referrals' but she also saw some 'outpatients and carers'. Natasha 'did half hour appointments with each individual, four in the morning and four in the afternoon'. She allowed a 15 minute break in between each person because she 'used to see nine people a day and it was back to back' which was too rushed.

In a similar regime to how Olivia provided Shiatsu, Natasha explained that people could have up to six sessions in hospital and some people would continue beyond these six sessions, for example, 'women who were often self-harming' were people who 'stayed on her books for quite a long period of time'. Following the first session, Natasha used MYMOP³⁶ to measure how people felt and to 'pinpoint what people would like from the session'. She felt that MYMOP was 'quite useful because she could show how things changed from session to session' and what she could 'actually achieve' through Shiatsu.

Natasha felt it was 'a very different dynamic working with people who were sectioned and who were in a custodial situation'. She felt that if she could help provide each person with 'some sense of light and wellness within their situation and validation of where they were' that was enough for her.

Natasha was 'never short of people wanting to participate' and she felt 'very humbled' because the patients who came for Shiatsu did not know what it was. Despite how they might be 'feeling vulnerable' and that being in hospital was a 'difficult environment as they were locked up with other very distressed people', they were 'willing to do this weird therapy' and lie down on a futon with someone they had never met.

Natasha felt that 'getting into NHS work was fantastic' as it had given her financial stability:

working as a private practitioner you're doing your promotions you know always thinking 'Oh where's my client? Am I going to be booked?' whereas if you're in the hospital you have clients on site and you're not running around endlessly um and clinically it is so interesting because you see um much more extreme cases. [Natasha]

³⁶ Measure Yourself Medical Outcome Profile

Natasha felt that 'generally in our private practices', Shiatsu practitioners will usually treat people who are 'well and focused on health maintenance' or maybe 'tweaking bits and pieces' and maybe coming as a 'sort of last resort with something a bit more extreme'.

Thus, in Part 1 I have discussed three ways in which qualified participants positioned their practice. These three ways broadly reflected how students envisaged their practice. These pathways to practice will be discussed further in the final chapter.

A particular challenge facing participants in private practice (CAM practitioners as well as those practising purely Shiatsu) was how to build their practice to the point where they no longer needed to support their practice through other paid work. This issue depended on personal circumstances (domestic and financial) and stages in the life course as illustrated in the above discussion.

Part 2 continues the trajectory of 'Getting out there to practise Shiatsu' by considering the challenges involved in building a private practice.

Part 2 Challenges of building a private practice

Part 2 of this chapter considers two key issues facing participants in private practice: how to market their practice to attract a client-base and deciding what to charge for a treatment.

Marketing strategies to attract clients

Most qualified participants had developed a marketing strategy. The main way in which they advertised their practice was via a personal website together with promotional material (for example, leaflets and business cards). Other activities included 'attending health awareness days', 'doing taster events' and

'occasionally tweeting' or 'doing all kinds of talks to anybody who wanted a talk'. The Shiatsu Society (UK) provides a wealth of information and guidance in this respect, including advice on how to set up a website and various leaflets, for example how to approach GPs. However, participants generally felt that although they valued the Shiatsu Society (UK) as an organisation and saw the need for a professional body, and valued the organised events such as Congress and that it provided useful information, they tended to belong to the Society for insurance purposes and did not feel that it was particularly useful in generating clients.

A key feature of most participants' promotional material included a general set of conditions that Shiatsu might be able to support; for example, most participants mentioned how Shiatsu could help with a sense of wellbeing, musculoskeletal issues and other general conditions such as headache or stress-related symptoms. Participants tended to list the sort of conditions that many of their clients gave as the reason for seeking Shiatsu. For example, Lavinia worked with a 'wide range' of different conditions:

I work with people with depression, I work with people with um er recovering from cancer, I work with people with Parkinson's Disease um I have worked with motor-neurone disease and also with a lot of muscular-skeletal – shoulders, backs, necks - all kinds of things and it really helps um and it's not Massage. People come thinking its Massage and they soon find out that it's not. [Lavinia]

In contrast, Maggie felt that 'very few' clients sought Shiatsu for muscular skeletal' reasons. Reflecting Nora's supposition that people tended to look for a practitioner who would suit them, Maggie felt that 'because of her age', she tended to 'attract older people' which meant clients with 'menopausal problems, divorce looming, divorce happened and death'. For example, one of Maggie's clients 'was bereaved' and 'had been coming for many years for Shiatsu'

because he maintained 'it just made him feel better'. Another client had recently developed alopecia which the client attributed to 'the stress that she was under'.

Maggie felt that people recognised Shiatsu 'helped their general wellbeing' and although she thought this was a 'fairly woolly phrase', her sense was that people felt 'they can cope better with the rest of their life' through having Shiatsu regularly. Maggie felt she knew this through her own experience of having regular Shiatsu:

I know because I have Shiatsu regularly that I find I feel ... that I have more energy like I've had a good ... I feel like I've had a good night's sleep irrespective of whether I have or I haven't but that sort of refreshed feeling ... and an enthusiasm to get on with stuff which otherwise I might say 'Oh well I'll do it tomorrow' ... [Maggie]

Despite the wide variety of conditions that participants purported could be supported by Shiatsu, most participants did not feel that their marketing material was very effective at generating clients. This included experiential endeavours. For example, in Stephanie's experience, although people will try Shiatsu at taster sessions, it was not the 'true Shiatsu experience' and highlighted this as one reason why it was not successful in attracting clients. Stephanie felt that people were reluctant to lie on a futon at a public event and she found she had most success in acquiring clients when she took her Shiatsu chair to health fairs as this was less public:

... I had a chair session ... I've just got people to come over and that was quite successful. They liked it um ... and I've got a few people who have transferred from chair then to try the futon and one of those ladies still comes so that was good. Yeah so I do like to um ... show people that there are different ways to receive Shiatsu not necessarily on the futon ... [Stephanie]

In contrast, in the context of a hospital and for the particular service users she worked with, Olivia felt by making a Shiatsu session 'quite public by doing it as a group, people were able to see what was going on so they could choose whether

it might be something that they would like'. Sally reflected that attending 'pampering days' as a means of generating clients was not that viable as she felt it was 'bad for business' as people tended to see Shiatsu as 'just a nice treatment' and would not attend if they did not feel well. Sally felt it was important that people should attend a treatment if they felt ill as her view was that was 'why they should be having Shiatsu as it might help them'.

Teachers' students were often potential sources of clients as people who volunteered to be the 'practice bodies' during training. However, the transition to becoming fee-paying clients was sometimes complicated. For example, during her training, when students were required to practice Shiatsu with no charge, Sally had a 'wonderful woman' who ran the village pub who become one of Sally's 'free bods' for two years during her training. However, when Sally explained to her 'practice bods', including the woman from the pub, that now she was qualified there would be a 'small charge', the woman from the pub stopped coming. After a period of 'three or four years', having had a 'massage' while on holiday abroad which reminded her of Shiatsu and how 'good it had made her feel', the woman from the pub decided to return to Sally to have monthly Shiatsu on a paying basis.

While it was difficult to attract clients by marketing strategies (outlined above), many participants felt that most of their clients came via 'word of mouth'. This usually meant recommendations from people who had already been to have a Shiatsu treatment. For example, the 'woman from the pub' who was one of Sally's 'free bods' during her training was 'one of the best people' to promote Sally as a Shiatsu practitioner:

you know people will be talking over a pint saying 'Ah he's not in tonight because he can't get up as he's got a bad back' and she'll say 'You should go and see [XXXX]'. [Sally]

Similarly, Joan's primary source of clients was 'ready-made' via the Cancer Care Centre and although not as paying clients, people would seek Shiatsu through recommendations either from other clients at the Centre or from the staff who worked there.

Thus, participants found that the most successful means of attracting clients was by word of mouth which highlights a particular issue in relation to the name 'Shiatsu' (discussed further in the next chapter).

Shiatsu – is it a dog? It could be flower arranging!

Participants generally reflected Leo's view that 'what stops people' from really explaining Shiatsu stems from something 'linguistic'. For example, Maggie felt that not only does the name 'Shiatsu' give no clue as to what it is' but also the word 'Shiatsu' was a 'difficult word for the English tongue to safely go round' and sometimes could be mistakenly said as 'Shitsu'. She felt this meant that often people were 'not comfortable with the word Shiatsu'. Most participants said that people often confused 'Shiatsu' with 'Shih Tzu' as in the dog.

However, most participants also reflected Madelaine's view that she 'did not know what else to call it'. For example, although Maggie wondered if 'maybe we need a new name for it', she did not think that that would be a 'good idea because it would just go back to square one then' meaning that 'Shiatsu' would need to 'reinvent itself'.

At one level, a key challenge expressed by participants was how to explain Shiatsu in a way that was meaningful to their audience. Participants appeared to adopt a flexible strategy and position or adapt their descriptions of Shiatsu according to their audience, striving to ensure that whatever description they used would have the greatest appeal. This was deemed to be important in two respects: first, successfully reaching their audience meant a greater likelihood of

generating clients. Second, given that Shiatsu provision tends to be mainly in the private sector, the corollary of successfully tailoring their descriptions of Shiatsu had a direct link to potential income.

For example, in explaining Shiatsu to someone who 'knew nothing' and who Doris felt might not 'instinctively' want to know about Shiatsu in 'great detail', she would restrict her explanation to describing what was going to happen during a treatment:

I would tell them it's a Japanese form of bodywork therapy that's rooted in Chinese medicine because I think quite a lot of people are becoming more familiar with Chinese medicine um and then like tell them that you work with um rotations, rocking, stretches and keep it quite physical in that sense. [Doris]

Using other body-based therapies that were more accepted by 'mainstream health care' was a common strategy to legitimise and give credibility to their explanations, particularly when the audience was not familiar with Shiatsu or where people were more 'scientifically minded'. Acupuncture and Physiotherapy were used most frequently, as not only were these therapies felt to be relatively well-known but also more accepted by mainstream health care.

For example, Anita reflected that when she first started training she would describe Shiatsu as 'it's a bit like Acupuncture but without the needles' based on how 'people seemed to be fairly positive about Acupuncture'. However, now she tended to 'describe it as a kind of bodywork, for example, like a cross between Physiotherapy and Acupuncture' although she 'did not think this was a good description'.

When trying to explain Shiatsu, Maggie often asked if she could demonstrate a bit of Shiatsu on the person's arm. She sometimes used pictures which showed Shiatsu being practised as she thought pictures instantly 'made it different from

conventional Massage because the person is dressed'. Reflecting many participants' comments, the way Anita explained Shiatsu depended on the background and beliefs of the person:

*because it depends I mean some people are very 'New Agey' and the more you could say about meridians and stuff like that the happier they are and most people I know are engineers or sort of sciency-minded so that kind of stuff really isn't attractive .. so if you say something like Physiotherapy even though strictly speaking it's not that accurate they'll go 'Ah Physiotherapy ... NHS ... so must be alright don't you think?'.
[Anita]*

A particular challenge was in finding a sufficiently short definition that would fit on a business card and, reflecting Anita's definition on first starting her training, Kat had decided that she was 'leaning towards Acupuncture without the needles' because it was 'sort of catchy'.

These comments highlight the difficulty in trying to explain a healthcare practice that has a complex theoretical and cultural base and sits outside of mainstream health care, in terms that would attract clients. In short, Kat sums up the difficulty of explaining Shiatsu:

people keep asking me and I just give them a blank look ... it's like I know what it is I'm qualified in it but trying to explain that to somebody whose never done anything like it ... [Kat]

Although the short descriptions such as 'Acupuncture without needles' belie the complex cultural and theoretical roots, and participants were often uncomfortable about using such definitions, there was a recognition that these pithier more catchy explanations that also used more well-known and accepted therapies were more effective in reaching target audiences, namely clients.

Conversely, Leo felt the problem was at another level, arguing that rather than saying Shiatsu was 'all one animal' it should be considered as a 'whole zoo'. In this respect he thought that Shiatsu should be seen in the same way as a 'whole

system' like Psychotherapy, which he saw as an 'umbrella term' for a lot of different therapies such as Gestalt Psychotherapy, Psychoanalysis, Transaction Analysis, Cognitive Behaviour Therapy which all have the same aim – namely to 'deal with people's emotional issues in different ways'.

In this sense, Leo makes a distinction from how Madelaine refers to Shiatsu collectively as a 'vast tool bag and a wide range of techniques from the hands-on healing to what is more like Osteopathic adjustments'. He saw Shiatsu as a whole system comprising different styles of Shiatsu, each potentially having a distinct name.

Charging strategies

Reflecting Madelaine's comment on how it was important to value one's services yet it was hard 'asking for money', participants generally felt there were some complex issues around charging a fee. For example, Sally had a client who could not afford Shiatsu but had 'an ill dog' on which her client had 'spent £1000s'. Although Sally had 'offered her free treatments' – which she thought was not a good idea as it 'took away the professionalism' – her client would not accept this offer.

Maggie felt that one of the issues around charging was how some clients – particularly if they were friends – lingered at the end of a session thus effectively extending the session:

people stay and chat – you know lots of body language and standing and walking towards the door, keys in hand, you know. [Maggie]

Although Maggie now practised from home, her experience of working in 'various clinics' highlighted how a 'proper receptionist' made 'a heck of a difference' to

how efficiently she could 'get people in and out' because 'people had a lot more professional approach to the appointment'.

Deciding on a fee level

Participants generally operated a flexible strategy around the rates they charged for treatments. For example, in deciding on the level of her fee, Stephanie explained how as students they were advised they could charge a 'nominal fee'. Stephanie's group agreed among themselves that £20 per session seemed 'fair enough' based on what a haircut or beauty treatment might cost. Stephanie's strategy during her training was to tell all her clients that she was charging half price to give them the idea that 'one day it would be £40 at least'. However, having only just qualified, Stephanie had decided to charge £30 per session as she thought the jump from £20 to £40 was 'too massive and a bit cheeky':

... so pitching it, you know, trying to get people to appreciate it after all this studying that I've been to, ... people spend £60 on a haircut... it's just trying to get people to understand what it's doing for them ... [Stephanie]

However, by the time she had paid for the rent at the venue where she mostly practised, Stephanie thought she was 'still not coming home with very much'. Whereas when there were no overheads (rent and petrol) – as in the case of the one client who came to her house for Shiatsu – it was actually £30 that she received.

Rita's 'usual charge' was £70 for an initial consultation of up to two hours and thereafter £40 per session. However, she felt she 'was a bit of a soft touch' and so occasionally she was open to negotiation if clients could not afford her fee. She explained how she had a client who was housebound and so she charged him half price. She wanted to try and 'be fair to everybody' but was more open to negotiation if people committed to having regular Shiatsu sessions.

Encouraging a sense of commitment

Also important to participants was how to generate a sense of commitment from clients which was felt to be more beneficial. Sometimes they would work out charging strategies designed to help persuade clients to have a series of sessions rather than one-off treatments.

For example, in Stephanie's experience people were more likely to attend 'even if you just charge £5'. Furthermore, she felt that by not charging anything, 'it devalues Shiatsu and all that training'. Rita reduced her fee to £30 for one particular client because they came regularly every month.

Part of Stephanie's business plan was to encourage people to take up an offer of three sessions for the price of two. The rationale for her plan was based partly on how she felt that not everyone could afford Shiatsu but also that they would gain more benefit from having three sessions:

I've spent a lot of the first session talking to them, asking them questions and then getting to know their body and they're finding out what I'm going to be doing to them so I always tell them the first session isn't the best ... so by giving three sessions I think it gives them the chance to actually see how they feel on the first one and compare after the two or three and then see if they want to take it further [Stephanie]

Joan's view was that it can be 'a long process' to get clients 'back anywhere near to sort of like full health again'. Her approach, both when working on a voluntary basis and with her other paying clients, was to encourage them to 'come on a regular basis' and, in a similar way to Stephanie, felt that a series of treatments was more beneficial:

if you come one week and then don't come for four weeks you know you don't get the full benefit but to maximise benefit come more regularly at the start ... [Joan]

At the Cancer Care Centre where she worked on a voluntary basis, they offered eight treatments initially and then made an assessment at the end of the series as to whether to continue or not. It was important to Joan to be honest with people and 'then leave it up to them'. Her sense was it might be different if practising Shiatsu was 'solely someone's business' but claimed that even if she was in that position, she would still be honest with people.

Charging a nominal fee

There was a general feeling that charging an appropriate fee – even a nominal fee or 'three for two' – gave Shiatsu some value which was deemed to be important. For example, as part of a plan to promote awareness of Shiatsu locally to GPs, Lavinia was aiming to do 'clinics in her home town once a month on a Saturday when the GP clinics are closed' and saw this as a way in which local Shiatsu practitioners could start offering Shiatsu as a 'possibility to people who are really desperate':

in terrible pain and have tried everything and don't want to carry on taking pain killers and will just give it a go because they haven't got anything to lose. [Lavinia]

She was proposing to 'charge a nominal fee' because – reflecting other participants' views in this respect – she thought it was 'important that something's given for the Shiatsu work' and there was a need 'to be careful about volunteering too much' because she felt that 'in a way people don't value it so much' if there is no charge.

However, it was felt by some participants that giving Shiatsu for free 'took the pressure off' and gave rise to a feeling of 'giving something back'. For example, despite indicating that she was considering 'letting Shiatsu go', Ellen felt she had enjoyed her experience of working on a voluntary basis for a charity event

because she was 'not being paid and the pressure was off'. As indicated earlier, stemming from the pressure of needing to do more treatments than she was used to doing during her training, led Doris to feeling that she was doing Shiatsu because she 'had to' do Shiatsu not because she 'wanted to'. Reflecting Doris' comments in this respect, Ellen's experience of the charity event led her to think:

actually maybe this is what I should be doing maybe I need a year or two of just receiving Shiatsu, giving Shiatsu and literally giving Shiatsu away.
[Ellen]

Similarly Joan was content to 'give' Shiatsu mostly on a voluntary basis because she was 'giving something back', and as indicated above, she did not need the money. However, although she was not interested in generating a big business, she did occasionally 'do a little bit' of Shiatsu either at clients' houses or her home and where she charged £20 for a treatment. Joan did not think she took a different approach when she was in a 'sort of like a paying situation' because she felt that 'at the end of the day it's about quality of treatment'.

Maggie felt that one of the 'constraints' on Shiatsu is the time it takes to do a Shiatsu treatment and this 'limits what a Shiatsu practitioner can earn'. Maggie's view was that 'because Shiatsu is not well known you can't charge the same amount as some of the other therapies'. Furthermore, she thought 'it very much varies according to where one practised':

I think in the city like London or whatever, you can get away with charging a lot more than you could in the more rural environs I work in ... I think ...
[Maggie]

One of Sally's clients who had experienced Shiatsu for the first time as a 'free twenty minute taster and loved it', had then gone on to book a 'full treatment'. Following the treatment, the client – who Sally felt would 'not be short of a bob or two' – suggested to Sally that she charged too much at £40 an hour. The

following extract has been written in a slightly different style to highlight the dialogue between Sally and her client as 'ventriloquated' by Sally:

She really loved it and then

She said, 'Well I will book a treatment 'cos I don't think it's fair if I just have the taster and so on' and

I said, 'No no there is no obligation' and

She said, 'No I'd like to book a treatment'

So she had a treatment and she paid for one treatment and at the end

She said, 'Do you mind me telling you something?'

and I thought, 'Oh here it comes' um ... so I said 'Go ahead' and

She said, um 'Well' she said 'I think you charge too much really' ...

Now and I should have said 'I charge £40 per hour which is about the going rate for a Shiatsu' ... and

She said 'I think you charge too much' and I thought 'Well that is rich coming from a retired ex-headmistress!' um and

She said 'I think people will baulk at paying that much' and I said

'Well that's what it is it is what it is' and she said

'Have you thought of cutting down and having a shorter treatment for less money because if you had say a twenty minute treatment and only charged £20 people would probably come?

*and I said 'No that's not the way Shiatsu works ... it takes 20 minutes to get to that point of relaxation when you can start accepting the healing'.
[Sally]*

Thus far, in the trajectory of 'Getting out there to practise Shiatsu', Part 1 examined three ways in which participants positioned their practice. Part 2

continued the trajectory to examine two key challenges in relation to those participants building a private practice. Most participants felt that it was more beneficial to charge a nominal amount than to offer Shiatsu on a voluntary basis. In marketing their practice, participants felt that word of mouth was the most successful way to generate clients. This highlighted a particular issue associated with the word 'Shiatsu' in that it is not a meaningful word in the English language. This issue will be discussed further in the final chapter.

Part 3 brings the trajectory to a close by considering ways in which participants explained their practice.

Part 3 Explaining how Shiatsu works

A key challenge expressed by participants was the difficulty in explaining what Shiatsu is. As such, they were practising a therapy that they believed in and were inspired by, yet could not straightforwardly explain. This exposes a potential tension between the theory and practice of Shiatsu. This final part examines the ways in which participants explained their practice and brings to the fore the tension between theory and practice first highlighted in the previous chapter in relation to students' experiences of training.

I identified five ways in which participants explained how Shiatsu works: 'Shiatsu as education', 'getting in touch with the body', 'getting fixed', 'working in partnership' and 'Shiatsu as spiritual'.

Shiatsu as education

Leo's particular perspective on explaining how Shiatsu works is that he saw it as 'education'. Leo reflected that during the early 1980s when he was developing his career, although he was basically 'still doing Zen Shiatsu' which he 'loved', he

'realised there was a whole group of clients who kept on coming back with the same problems'. He began to question whether he was 'doing them any good' and started to work with his clients in a more 'interactive' way so they were 'moving and experimenting themselves'.

From a theoretical perspective, Leo did not see 'meridians as channels along which chi flows' as was commonly explained by others in the Shiatsu world.

Instead Leo saw meridians as 'pathways of integration':

*The people who come for Shiatsu don't know what chi is and they don't know what energy is or whatever but I ... see [meridians] as pathways of integration in the body so that er and that in a sense they're in the nervous system um but in, you know, the nervous system has a model of the body and that my belief is that meridians are part of that model but lines along which muscles collaborate in order to do holistic movements.
[Leo]*

Leo developed a style of Shiatsu whereby Shiatsu was 'really coming from experience rather than an idea' whereas Shiatsu theory 'came from an idea rather than from practice'. He spent 10 years 'working with disabled children' mostly during the 1980s in which he began to develop a 'complete system' based on his proposal that the 'six channels, which combine one meridian in the arm with a different meridian in the leg, formed a whole body channel'. He suggested that 'these channels trace the development of movement in babies precisely'. Leo suggested that although developmental psychologists have showed that 'physical skills are the foundation for psychological and emotional development', to Leo these psycho-motor capacities 'corresponded very closely to the Oriental Qi function of the meridians'. He felt that this 'connection gave a satisfying explanation of the channels'. Thus his essential departure from other Shiatsu theorists, was that 'working with meridians was more an education rather than a treatment' and 'meridians were lines along which we learn rather than blood vessels which can get blocked'.

Getting in touch with the body

Many participants felt that Shiatsu helped people to get in touch with their bodies. For example, perhaps based on her own health-related experiences of ME, Anita felt that 'a lot of people are disconnected from their bodies and, if you have a chronic condition and you haven't got that kind of connection with your body then you are in quite an uncomfortable place':

the aspect of actually supporting people and getting them to be a bit more into their bodies ... maybe not see their bodies as their enemies when they are trying to be well and it's all going wrong ... I like that and that's part of why I keep doing it. [Anita]

Joan's view was that the stretches helped to open the joints and release 'stagnant energy' and she thought that most of her clients not only liked this experience but also that it helped to 'put them in touch with their body'. Rita also felt that 'people gain body awareness and energy awareness as they receive' and how through bodywork they start to notice the aches and pains that they might not have previously been aware of.

In Olivia's experience, she felt that some service users had had difficult experiences of medical care and were often 'very disempowered'. She felt that bodywork was 'the way in with people' and particularly for people who were 'perhaps a little bit avoidant, very damaged, very hurt, very low and very angry sometimes with all sorts of very complex things going on'. To Olivia, it was 'about really touching and holding somebody and particularly for the very long-standing mental health service users who had had no therapeutic touch or perhaps the touch they had had was inappropriate or violent or just very uncomfortable'.

Some participants felt that after a few sessions of Shiatsu, clients became more in touch and able to express what was happening in their bodies. For example, Sally would often notice that when clients came for Shiatsu for the first time, they

were 'not necessarily aware of their bodies at all'. However, if 'they started coming on a regular basis, after a few months instead of saying, 'Well I'm fine' they would say, 'Well I did have a small pain just here or I did some gardening and noticed my arm was feeling a bit stiff'.

Getting fixed

One of the 'eye openers' experienced by students during their training was the realisation that they could not 'fix everyone'. For example, during her placement, one of Kat's clients returned each week to say she 'did not feel any better' and that Shiatsu had 'not done anything' and this experience 'really shook' Kat's confidence. Similarly, Sheila felt she 'had to learn how to not take things personally' when she perceived that a client might be being critical of her and she experienced 'that momentary feeling' that she might have done something wrong.

These students' confidence returned when they noticed how other students had 'gone through this experience' as illustrated by Kat:

well maybe it's not my crap ability maybe I can do it it's just this person isn't ready for this yet. [Kat]

In contrast, more experienced participants did not expect to cure everyone. For example, Olivia did not 'set out with an expectation that necessarily everyone would be better' within the timescales she was required to work with but she 'hoped for them to feel differently about things'. She felt she had to 'manage it that way' and 'particularly when people were very stuck' and she did not know 'where to start with things' or the person for 'one reason or another' was unable to help themselves. Although she sometimes found it 'frustrating' when she was 'making headway with people' and she knew that they would not 'do a lot after their six sessions and could go back to square one', she felt 'less frustrated' if she

viewed Shiatsu as a 'starting point' because she felt that 'obviously not everybody fits in that box or that timescale of six weeks and gets better'.

Just as students expected that Shiatsu might effect a 'quick cure', many participants reflected that clients often came to 'get fixed'. For example, in Lavinia's experience 'even people with incredibly chronic conditions' who had been through the 'whole medical profession and tried everything medically' but with no results would come for Shiatsu and 'expect immediate reactions'. Participants tended to reflect Lavinia's view that the 'body doesn't work like that' and a 'chronic condition is going to take a bit of time to shift' because it had 'taken years to build up it was hardly going to shift in two or three sessions'.

Leo felt that Zen Shiatsu focused on 'those processes that can change in the present but it does not take any account of resistance'. Thus Leo thought that Zen Shiatsu was 'really good for people who were in acute situations and needing support' – perhaps needing to be 'fixed' – but that it was not very good for people who were in 'chronic resistance to a process'. Equally, Leo felt that the style of Shiatsu he had developed 'might sometimes have too much gravitas and depth to it for some people who might just want to feel good and want to feel relaxed'.

Working in partnership

In contrast to those people who came to 'get fixed', many participants found that people came for Shiatsu because they were seeking to understand their bodies and were 'very interested to work with' them in a 'kind of partnership'. For example, helping her clients to 'discover what suits them and what supports them in their lives' was an aspect of her practice that 'particularly inspired' Lavinia. Similarly, Olivia found that although there may be 'steps backwards', most people

who were 'stuck' were willing to recognise that there was an 'issue going on' and work with her to 'deal with it'.

Participants generally thought that maintaining an 'open' relationship with their clients was important. For example, Lavinia based her relationship on 'an agreement' such that if her clients felt they were 'not getting something from it' or that she was 'not helping somebody' then they would not continue.

However, participants felt there was an important balance to be struck between 'instilling confidence' yet not allowing people 'to be dependent' on them. For example, Olivia had learned in her first year not to 'leave it open-ended' because otherwise she would 'end up working with the same four people indefinitely' and as such, she limited the number of sessions to six per service user. She tended to focus on a 'particular theme' with the aim of looking at ways of enabling people to begin to support themselves.

Shiatsu as a spiritual practice

Many participants felt that Shiatsu practice was linked to a spiritual practice in the sense that it was connected to a 'deeper level of meaning'. This more nebulous aspect was not only associated with self-exploration but also related to the way in which participants practised Shiatsu in partnership with their clients as a 'voyage of discovery' and which, for most participants, felt 'rewarding'. For example, Joan felt that she would be happy if she could give 'something to people that creates that sort of emotion and feeling where they feel good'. Rita referred to the 'touch aspect' as generating 'that nurturing feeling' which she believed to be 'worth much more than anyone ever really appreciates'. Stephanie thought that Shiatsu 'seems to help people to just understand how their lifestyle is'.

Some clients 'came for one-offs' but sometimes returned after a period of time. Perhaps reflecting the spiritual aspect of Shiatsu, Madelaine supposed that one of the reasons why these clients returned was 'there was an inner knowing' in some people who came for Shiatsu and 'something in there just knows it did them good' and they think they need to 'get back to it'. Madelaine felt that some people 'don't just quite get it at first'.

Participants generally felt that while Shiatsu may have immediacy in the sense that 'it works with whatever is presenting at the time', it was also 'adaptable' and could work with what people were 'asking for'. Participants often made a distinction between Shiatsu and Massage claiming that Shiatsu is 'more than Massage'. For example, Doris felt she was 'more aware of a deeper connection' between the two people during a Shiatsu treatment than Massage reflecting a more spiritual aspect.

Reflecting how participants felt that sometimes Shiatsu can enable participants to get in touch with their bodies, Olivia felt that Shiatsu was a way of:

... opening up that doorway for a dialogue to start to happen about how people are and how well they're looking after themselves and how well they're enabled to do that ... [Olivia]

For example, Lavinia viewed the occasions when her clients had not got 'anything particularly happening' as a 'special time' in that they could work on the 'deeper layers' which she described as the 'more long-term stuff' which was so 'embedded' that often clients were not aware of it. She felt that making contact with someone's 'inner potential and bringing out the good, the strengths' and allowing these to come to the fore was more 'powerful' than concentrating on what was 'wrong or the symptoms'.

Connected to the nebulous effect of Shiatsu, most participants felt that Shiatsu works in ways that are difficult to explain, but they felt that perhaps Shiatsu enables people to get in touch with something that 'they don't really necessarily realise they need or feel they can confront'.

Concluding comments

This chapter has examined ways in which participants positioned and explained their practice. It has highlighted some key tensions and turning points in relation to this part of the trajectory 'Getting out there to practise Shiatsu', particularly in respect of the status of knowledge and how to earn a living as a Shiatsu practitioner.

Analysis of qualified participants' accounts suggested three groups: those who identified themselves as Shiatsu practitioners whether in private practice or practising on a voluntary basis; practitioners who were practising Shiatsu as part of their suite of complementary therapies and saw themselves as complementary practitioners, and finally participants who perceived they had identity as a Shiatsu practitioner in an NHS setting. The students' imagined trajectories broadly reflect these three groupings.

The strategies undertaken by participants in order to be accepted to practise Shiatsu within an NHS setting suggested that it was more important that the participants acted professionally, were trusted and fitted in with existing policies and practice, than concerns about Shiatsu being a non-mainstream healthcare practice. The participants appeared to have a fair amount of autonomy in how they practised Shiatsu and in contrast to those participants who worked alone in their private practices, they felt valued members of teams, working particularly closely with OT departments. Accessing the NHS highlighted the particular issue

of Shiatsu being a marginalised healthcare practice outside of mainstream health care.

The two participants working in NHS settings and the one participant working at a Cancer Care Centre had a source of 'ready-made' clients or patients which meant they did not face the key challenges facing practitioners in private practice of how to market their practice and attract clients as well as developing a viable charging strategy. Often participants adopted a flexible approach or sliding scale to setting their fee, but most felt that charging a nominal amount for a session was more beneficial than not charging anything.

Although there is never complete job security, participants felt that working in the NHS gave them greater financial stability. In contrast, those working in private practice faced the challenge of building and maintaining a viable practice. For some participants this meant maintaining other paid work and the challenge of taking the risk of letting go of this work in order to give space to expand their Shiatsu practice.

Some participants preferred to practise on a voluntary basis (usually having other means of income) but still identified themselves as Shiatsu practitioners.

Participants who had been practising the longest earned their living through Shiatsu, and also tended to teach Shiatsu, and two participants had set up their own school.

A significant challenge appeared to relate to the difficulty in defining Shiatsu, and this was particularly apparent in marketing strategies where word of mouth was the most effective means of generating clients and which was largely based on people having experienced Shiatsu. There was a clear sense in which participants felt they had to adapt their definitions of Shiatsu to suit the audience. Often participants would draw on more accepted healthcare practices such as

Physiotherapy and Acupuncture which often belied the complex philosophical ideas underpinning Shiatsu theory and practice. The most long-standing participant suggested that Shiatsu was more than a vast 'tool bag'. Rather it was more like a whole system comprising different and sometimes competing styles of Shiatsu, highlighting a significant tension with the Shiatsu community in this respect. This tension was reflected in the previous chapter in how some students struggled with the different bodies of knowledge during their training but tended to feel more comfortable once they had developed their own style, highlighting a particular turning point for students in this respect.

Clients appeared to go for Shiatsu treatments for a range of reasons. The final part of the chapter focused on the ways in which participants perceived Shiatsu to work. This included how Shiatsu had the capacity to open up a dialogue and how Shiatsu enabled clients/service users to get in touch with and understand their bodies. Participants placed importance on working in partnership with people who came for Shiatsu and many participants saw Shiatsu as a spiritual practice in how it connected to a deeper level of meaning.

Thus the two data-led chapters, 'Getting into Shiatsu' and 'Getting out there to practise Shiatsu' reveal the complexity of participants' journeys into Shiatsu practice. As argued in Chapter 3, Part 3 ('Generating a landscape of practice'), participants' wide range of experiences and differing positions in relation to their particular stages their life course generated a rich landscape of practice. I argue that this diversity reinforces the case for one-shot interviews as discussed in Chapter 3 in providing not only a temporal dimension but also in relation to where my participants were in relation to practising Shiatsu³⁷. Furthermore, I argue that this diverse landscape of practice is a particular strength of my study. The

³⁷ Appendix 08, Summary of participants' characteristics, highlights the diversity of influences and experiences within this landscape of practice.

landscape of practice highlights connections to wider societal factors, particularly in relation to career structures and earning a living.

In the final chapter 'Shiatsu practitioners: forging a path through a landscape of practice', I will examine participants' journeys into practice not only in relation to the sociology of the professions discussed in Chapter 2 but will also bring together neo-Weberian theory with Etienne Wenger-Trayner's theories of social learning.

CHAPTER 6

Shiatsu practitioners: forging a path through a landscape of practice

Introduction

As the title suggests, the focus of this thesis was to explore the experiences of Shiatsu practitioners and their pathways to Shiatsu practice. From a methodological position based on ethnographic narrative inquiry, the study did not seek to test specific propositions; rather it was exploratory and has identified a number of themes and tensions and, as will be discussed in the final part of this chapter, also highlighted some emerging questions.

Participants comprised a mix of people, some of whom had self-selected and others that I had specifically approached for their particular position in relation to Shiatsu practice. Thus the range of participants recruited in relation both to their different stages in their life course and Shiatsu practice represents a particular strength of this study. In addition, I have argued that my experiences of being a Shiatsu practitioner allowed me 'deep familiarity' with the field and thus a resource with which to examine my participants' accounts in order to produce a nuanced overall analytic story. I include my reflections on this process later in this chapter.

Analysis of the data was based on four key components of an analytic framework as discussed earlier in Chapter 3, Part 3 ('Analytic framework'). Summary descriptors of the analytic framework comprised:

Trajectories – form a 'continuous motion in relation to a field of influences which connect with the past, the present and the future' (Wenger 1998, p. 154)

Turning points – are ‘moments when the narrator signifies a radical shift in the expected course of a life’ (Riessman 2001, p. 705)

Social positioning – refers to the ‘way in which participants choose to position themselves socially in relation to others’ and provides a ‘useful point of entry’ for analysis (Riessman 2001, p. 701)

Landscapes of practice – refers to a ‘body of knowledge’ best understood as a ‘complex system of communities’ including the boundaries between them (Wenger-Trayner et al. 2015, p. 13).

Chapters 4 and 5 (the two data-led chapters) drew together individual participants’ trajectories, turning points and ways in which participants positioned themselves in relation to Shiatsu practice. Furthermore, these two chapters – which collectively outlined an overall trajectory – form a complex connection of pathways and experiences or ‘landscape of practice’ (Wenger-Trayner et al. 2015) reflecting participants’ pathways to Shiatsu practice. This landscape of practice revealed two key tensions as highlighted below.

First, there was a significant tension between the knowledge underpinning Shiatsu – which many participants found meaningful – and scientific knowledge. This tension was exposed in two key ways: how to describe or explain Shiatsu and the uneasy fit between the different bodies of knowledge being taught in the Shiatsu baseline syllabus. A second tension stemmed from issues around work and was revealed in the ways in which participants sought to earn a living through Shiatsu in a scientifically dominated healthcare arena. These two tensions will be discussed further in this chapter.

As discussed in Chapter 2, Part 2, (‘CAM and the evidence-based debate’), CAM research funding has mostly supported studies that focused on demonstrating the

evidence and efficacy of CAM therapies. Although in the past five years, there has been an increasing number of studies of CAM practitioners, there is still a paucity of literature in this area; and specifically in a UK context. In my discussion, I draw particularly on the work of Ursula Sharma and Gavin Andrews, because of their specific focus on UK CAM practitioners; this is significant, as discussed earlier, because of the legal differences between the UK and other countries. However, Sharma's (1992) study of people who used and practised CAM remains the most detailed examination of the field.

It seemed particularly relevant to discuss my findings in the context of Sharma's (1992) UK-based study of CAM practitioners, which had a similar methodology involving in-depth, ethnographic interviews. As highlighted in chapter 3, the depth of Sharma's (1992) study not only provided a rich but also a methodologically comparable resource to help make sense of and discuss my findings. As such, although there have been other studies (mentioned in Chapter 2), Sharma's study to date remains the most relevant to my work.

As discussed in Chapter 2, my research is broadly situated within the sociology of the professions as this provided the wider academic context for the particular focus of the research questions. The review examined how a neo-Weberian perspective of the professions accounted for the rise of the medical profession and how the privileging of scientific knowledge led to the subsequent marginalisation of healthcare practices not grounded in scientific methods (Saks 1995a). However, in the process of analysing my data, I became increasingly aware of the relevance of the theoretical perspectives of Etienne Wenger-Trayner's theories of a social model of learning and specifically in relation to its connection between knowledge, identity and professionalisation (discussed in more detail below in Parts 2 and 3). Furthermore, I suggest links between

Wenger-Trayner's theories of social learning and neo-Weberian theory in relation to the sociology of the professions. Therefore, I bring together these different theoretical perspectives to discuss the themes and tensions.

This chapter is structured in five parts: first, I revisit the literature discussed in the review highlighting the key turning points that led to the arrival of Shiatsu in the UK and examine these in relation to participants' pathways to practice. Second, I outline the key components of Etienne Wenger-Trayner's theories which have particular relevance to making sense of my data. In the next part I discuss these theories in relation to participants' pathways to practice. In the penultimate part of this chapter I reflect on my experiences of carrying out this thesis. Finally, I draw together my key arguments, discuss potential transferability of this work outlining limitations in this respect, and suggest areas for further research.

Part 1 Three key turning points – the sociology of the professions

Although I have used turning points as part of the analytic strategy in relation to participants' experiences, the review of the literature in Chapter 2 revealed a number of turning points in relation to the sociology of the professions which led to the arrival of Shiatsu in the UK. Therefore I suggest that turning points can be used not only to understand individual participants' experiences but also the field of CAM; and more specifically, Shiatsu. In this first part, I draw attention to three key turning points. First, in the general context of CAM and where the scene unfolded, was the passing of the Medical Registration Act (1858) which gave rise to the field of CAM as discussed in relation to neo-Weberian theory. Second, was the medical counter-culture period during the 1960s and 1970s, when people began to question and seek alternative ways of looking at health. Third, was the

professionalisation of CAM during the 1980s when CAM therapies sought to become more accepted by adopting a model of professionalisation based on that of the fully-fledged professions such as medicine.

The scene unfolds – Medical Registration Act (1858)

This first turning point serves as the sociological framework for the other two turning points (counter-culture and professionalisation). Thus, although not specifically arising from the data or grounded in the participants' experiences as are the two subsequent turning points, its purpose is not only to set the sociological scene but without it, the subsequent discussion of the counter-culture and professionalisation of Shiatsu has no foundation. In other words as discussed in the review of the literature, the key point of the neo-Weberian perspective in respect of CAM, as argued predominantly by Mike Saks, is to demonstrate the effective marginalisation, following the Medical Registration Act (1854), of the diverse array of healthcare practices to a position outside of statutory healthcare provision. From a Foucauldian position, the power to marginalise and also to incorporate CAM (Stone 2002b), stemmed from how scientific knowledge was considered to be the dominant form of knowledge (Saks 1995a). The process by which medicine became a fully-fledged, legal, state-supported profession to which entry was restricted, involved creating a codified body of knowledge that was taught and credentialed (Saks 1995a). As such, through a process of professionalisation which privileged knowledge grounded in scientific orthodoxy, a structure was thereby generated which created a platform for a state controlled or orthodox and effectively dominant, form of health care (Saks 2006). Effectively, this was the turning point at which biomedicine 'came of age' (Bakx 1991, p. 22) and at the same time, crucially, although healthcare practitioners who were not state registered could continue to practice under Common Law, they were essentially marginalised by being placed at a

substantial legal disadvantage (Saks 2006). Thus, although not called 'Complementary and Alternative Medicine' as such at this point, this was effectively when the field of CAM came into being. However, Bakx (1991) argues that 'folk' medicine never actually disappeared; rather, post-industrialisation, biomedicine became pre-eminent in the field of health and healing and effectively 'eclipsed', temporarily, other forms of health care (Bakx 1991).

The birth and eclipse of Shiatsu in Japan

In parallel to the marginalisation of healthcare practices not rooted in scientific knowledge, healthcare practices in Japan around the beginning of the 20th century were also undergoing change in the context of the increasing dominance of scientific knowledge in relation to health. As discussed in Chapter 2, Part 3 ('Shiatsu and Japan'), this was the point at which the word 'Shiatsu' came into being as a way of being able to continue to practise manual therapies without incurring a penalty through lack of licensure (Kishi and Whieldon 2011). I suggest that there are two key points of significance in relation to the term 'Shiatsu' in this context as discussed below.

First, although not necessarily known as 'Shiatsu' in Japan until the early part of the 20th century, it was historically embedded and understood in Japanese culture and was practised informally in several different ways. In contrast, to Japan, Shiatsu is not a culturally and historically embedded word. I suggest that the historical and cultural difference between Japan and the UK in relation to the word Shiatsu is significant and will be discussed further in Part 3 of this chapter under the heading 'Knowledgeability'.

Second, the legitimisation of Shiatsu by the Japanese Government around the turn of the 20th century paralleled what was happening in the UK by way of scientific knowledge dominating healthcare practices. Although less dominating

than the UK – possibly because of its cultural significance – the Japanese Government required the knowledge base underpinning Shiatsu to be codified in more scientific terms (Kishi and Whieldon 2011). Hence, although Shiatsu was culturally rooted in Japanese society, the same tension between what was considered scientific and non-scientific knowledge existed in Japan as in the UK in relation to health. In this sense, although Shiatsu was ‘born’ having evolved from similar traditional therapies, it was also subsequently eclipsed in Japan for several years by the dominance of scientific ways of looking at health.

Although there appears to be no reported use – at least to my knowledge – of a therapy by the name of Shiatsu prior to the 1970s in the UK, one might speculate that there were possibly eclipsed pockets of use resulting from people’s travels between the UK and Japan.

Thus the privileging of scientific knowledge continued to ensure that biomedicine maintained a dominant position in the UK in relation to healthcare practices until the period of the medical counter-culture during the 1960s and 1970s (Saks 2000).

Counter-culture – explorations and identity

As discussed earlier in Chapter 2, Part 1 and Part 3, a wider societal change in the UK characterised by a growing mistrust and questioning of authority included a ‘medical counter-culture’ (Saks 2006, p. 74) in which people were starting to challenge the expert knowledge of medicine and accuracy of testing pharmaceutical drugs (Kelner et al. 2006). This represents a crucial turning point in the trajectory of marginalised healthcare practices and is reflected in the experiences of some of the older participants in this study in their accounts of what drew them to Shiatsu. These turning points were often associated with exploratory experiences and linked to identity formation as revealed through the

participants' personal narratives and life stories or socially situated actions and identity performances (Mishler 1999).

As discussed in Chapter 4, Part 1 ('Voyage of self-discovery'), some participants talked about their early life experiences – an 'unfolding scene' – in which they expressed or displayed a sense of who they wanted to be and how they wanted to appear. Many participants in this study perceived Shiatsu as being linked to spiritual practice in the sense of self-development associated with exploring themselves and their experiences. Sharma (1992) perceives that being spiritual reveals a 'curiosity about human interactions and psychology' (p. 133). In this sense participants identified their experiences in relation to Shiatsu as a more meaningful way of 'becoming who they were', reflecting how identity construction is ongoing while also being mediated through different experiences (Wenger 1998, Wenger-Trayner et al. 2015).

For example, when Leo talked about how he became a hippie after leaving school, this is not only reflected in how he wished to portray his identity but also – though not expressed as such – his experiences coincided with the period of the sub counter-culture from the mid-1960s to the mid-1970s. Although Leo's description of how they 'did herbs' is possibly reminiscent of the 'wise women' and 'cunning men' who practised forms of healing and folk medicine in an open market prior to the Medical Registration Act 1858 (Porter 1988), the crucial difference is that Leo and his friends were practising herbs and astrology in an era when it was widely perceived that biomedicine offered the 'only alternative', because it carried the authoritative approval of science (BMA 1986).

Sharma (1991) argues that the question 'Why do people become complementary practitioners?' can be answered on at least as many levels as the question 'Why do people use complementary medicine?' (p. 127). By this, Sharma is suggesting

that what motivates people to explore alternative ways of supporting their health is also linked to their motivation to practise, and my data support this.

For example, as part of a growing interest in, and move toward, seeking different approaches to health, as discussed in Chapter 4, Parts 1 and 2, some older participants spoke about early life health-related issues during the 1970s and early 1980s as important experiences that drew them to Shiatsu. This is consistent with Sharma's (1992) finding where about a third of her participants mentioned illness experiences as having influenced their thinking about sickness and healing. Fulder and Munro's (1985) study revealed how people seeking CAM during the 1970s and early 1980s had not lost confidence in orthodox or mainstream health care but were, nevertheless, turning to CAM practitioners because they felt more supported through greater contact time in consultation time. In this study, in cases of older participants' experiences of illness during the 1970s, most of these participants felt more supported by Shiatsu. Thus in this respect, experiencing illness and finding Shiatsu more supportive than orthodox health care were important positive turning points for some participants.

Exceptionally, Sally reveals how her experiences of illness and particularly the death of her son led to her complete loss of faith and trust (Giddens 1991) in orthodox medicine. Her experience of orthodox medicine can be viewed as a 'provoking agent', which led to a negative turning point (Rutter and Rutter 1993, p. 357) leaving Sally searching for many years for a meaningful way to support her health.

Searching for more meaningful ways of supporting their health and how this drew them to Shiatsu is apparent not only in older participants' accounts of illness during the 1970s and early 1980s but is also revealed in participants' more recent accounts (for example, Nora and Ellen). This suggests that searching for more

meaningful ways to support one's health remains an important motivating influence toward becoming a Shiatsu practitioner.

However, although Andrews and Hammond (2004) posit that, 'witnessing/experiencing the success of CAM' was the most frequent motivation cited by their respondents, many respondents had multiple motivations. Their interviews revealed 'complex and very individualised stories' in relation to the therapists' pathways to practice (Andrews and Hammond 2004, p. 47). Sharma (1992) refers to this variety of influences and contingencies as 'layers of past experiences and motivations' (p. 127). My data support Sharma's conclusion that practitioners' trajectories into practice are not easily categorised, as my participants told highly individualised, layered, and often complex stories. Participants' ideas and experiences of their health and how these aligned with Shiatsu appeared to be a significant motivation for many, and this supports the findings of other researchers in relation to CAM as discussed in Chapter 2 (see for example, Astin 1998, Bishop and Lewith 2010, Sointu 2013). Aligning of ideas around health in relation to bodies of knowledge will be discussed further in this chapter in the context of Etienne Wenger-Trayner's theories of social learning under the heading of 'Pathways to practice'.

Professionalisation of Shiatsu

A significant turning point in the trajectories of CAM in the UK is associated with the move to professionalise CAM therapies (Cant and Sharma 1996c). As discussed in Chapter 2, Part 2, ('CAM and professionalisation'), professionalisation of CAM therapies – which included Shiatsu – during the early 1980s, was an attempt to gain credibility as legitimate healthcare therapies (Cant and Calnan 1991, Cant 1996). Prior to the move to CAM professionalisation, collective excitement about alternative medical ideas and enthusiasm to revive

CAM therapies was primed and sustained largely through charismatic leaders (Cant 1996).

As discussed in Chapter 4, Part 3, in Leo's case, his experiences of attending workshops and other Shiatsu-related events were deeply inspirational. These experiences led to him joining other contemporaries to seek to professionalise Shiatsu by creating the Shiatsu Society (UK) in 1981 and setting up its associated training programme. Significantly, with no formal training because none existed, these people then moved into positions of becoming charismatic leaders, inspiring others to become interested in Shiatsu. This process will be discussed further in Part 3 of this chapter in relation to Etienne Wenger-Trayner's theories specifically in relation to the concept of 'legitimate peripheral participation' under the heading 'Pathways to practice'.

Also discussed in Chapter 4, Part 3, participants' more recent experiences of retreats appeared to have a profound effect on them. In many cases it was the person leading the retreat and the way they conveyed the ideas underpinning the philosophy of Shiatsu that really seemed to convince people to want to train in Shiatsu. As such, these leaders of the retreats reflect Cant's (1996) notions of charismatic leadership in that they were not only trusted as leaders but were also inspirational in relation to their knowledge. Thus, this study demonstrates that the charisma of those people leading Shiatsu events remains a significant catalyst for some participants in influencing them to become interested in Shiatsu training.

Acting pragmatically

Although some participants were pulled or drawn to Shiatsu as it felt meaningful, as discussed in Chapter 4, Part 4, other participants signed up for Shiatsu training without a clear sense of what they understood it to be. However, in contrast to Sharma (1991) – who suggested that participants' decisions to train in

a CAM therapy seldom reflected an arbitrary or unpremeditated 'jump into the dark' (p. 13) – several participants in this study had had no experience or even, in some cases, prior knowledge of Shiatsu before signing up for Shiatsu training. These participants' primary motivations for training in Shiatsu were largely pragmatic; for example, taking up Shiatsu as part of a degree or as a change of career. Thus, there was no sense in which they were drawn or 'pulled' toward a particular body of knowledge; rather they were exploiting the professionalisation of Shiatsu as part of gaining a qualification.

Furthermore, my data did not altogether support Sharma's (1992) finding of a tendency for occupational individualism, which she refers to as a preference for autonomy and for working outside of hierarchical structures, and for independence in everyday work. In contrast, many participants – also evidenced in the students' imagined trajectories – would, in fact, prefer to work in large organisations. Although some individuals displayed a tendency for occupational individualism (for example expressed as being a 'free spirit' or seeing self-employment as providing a means of living more flexibly than institutionalised work) I suggest that this was more closely associated with setting up a business as a way of earning a living because there were few, if any, opportunities to practise Shiatsu in any other way. This final point highlights the marginalisation of Shiatsu as a healthcare practice in relation to the wider societal and structural context and which will be discussed further below under the heading 'A healthcare arena'.

Earning a living

In contrast to the most common aim of the participants in Andrews and Hammond's (2004) study – which was to develop their businesses and eventually to work exclusively full-time – not all participants in this study had a clear sense

that this was their objective. As discussed in Chapter 5, Part 2, of those participants who were thinking about going into business, this represented a significant challenge and very few appeared to have much experience in this respect – a finding also supported by Andrews and Hammond (2003). Building up a viable private Shiatsu practice was a significant challenge and the transition from supporting their practice through other paid work to earning a living solely through Shiatsu involved an important turning point for some participants. However, the way in which they described their experiences of adjusting and seeking to move forward appeared to be more associated with ‘trusting the space’ than being grounded in business knowledge.

Thus, for the qualified practitioners in private practice in this study, setting up in business was not so much a preference but more about being ‘pushed’ into this position, a point highlighted by Sharma (1992) in relation to nurses seeking to practise CAM within the NHS but finding ‘little scope to pursue these interests or skills within the NHS’ (p. 131).

In contrast to those seeking to earn a living through Shiatsu, some participants were less sure whether they wanted to earn a living in this way as this would ‘spoil’ the experience of Shiatsu, preferring instead to practice Shiatsu on a voluntary basis (for example, Doris and Joan). Although there was a sense in which some participants felt that giving Shiatsu on a voluntary basis took the pressure off and created a sense of ‘giving something back’, my data support Sharma’s (1992) findings in relation to the dilemma facing participants in that it was important not to provide Shiatsu free of charge, because to do so also conveys a sense that it is worthless and so a small fee ensures it has value.

However, as Sharma (1992) noted, the position of CAM practitioners with respect to paid work is ‘full of contradictions’; many CAM practitioners identify with a

'professional ideal of public service yet their services are only accessible to those who can pay' (p. 173). Thus, this dilemma highlights a tension between professional altruism and commercial interest (Sharma 1992), a commonly-cited tension reported by Andrews and Hammond (2003) which is reflected in my participants' accounts of how some would prefer to be in a position where they did not charge for Shiatsu. This did not necessarily equate to giving Shiatsu away on a voluntary basis but was also related to being part of an organisation where they did not directly charge clients for Shiatsu.

Despite a tension in relation to setting a fee, participants tended to be confident about their capacity to evaluate their time in a way that was satisfactory to themselves and realistic in terms of the market for their services, supporting Andrews et al.'s (2003) findings in this respect. Whereas Andrews et al. (2003) found that some of their participants perceived that in order to be a 'good therapist' (p. 162) it was necessary to make certain financial sacrifices (which related to making concessions and setting variable fee levels), this did not reflect my findings. Although there might to some extent be an altruistic element, participants in this study who were operating a sliding scale in relation to fees did so predominantly with the aim of trying to ensure a sense of commitment from their clients. Participants worked with their clients or service users in different ways in this respect.

Shiatsu as education

Ways of working with clients are aspects of professionalisation which are incorporated within the ethics code of a professional body. For example, the Shiatsu Society (UK) code of ethics is designed to guide its members in the minimum standards of professional conduct (Shiatsu Society 2014). Although an ethics code generally sets out formal rules or advice for its members particularly

in respect of practitioners' 'therapeutic responsibility' in their encounters with patients or clients (Stacey 1994), there are aspects of practice about which it is difficult to be precise.

Many participants felt that Shiatsu practitioners and the way they worked with their clients or service users involved a connection to a deeper level of meaning in a spiritual sense, and these findings support Long's (2009) study of Shiatsu practitioners. Participants argued that a Shiatsu treatment had the potential to generate more than just a nurturing feeling associated with gentleness and care that is normalised in the alternative health setting (Sointu 2013), but that it transcended this aspect through affording a deeper connection with their clients. This more spiritual connection was sometimes used to distinguish Shiatsu from other therapies – particularly other body-based therapies such as Massage.

In contrast to Stone and Matthews (1996) who argue that CAM relationships stress the centrality of patient self-responsibility, as discussed in Chapter 5, Part 3, participants in this study felt that Shiatsu could be used to help people become more aware of their bodies in general, and placed importance on working in partnership with their clients and service users. In this respect they reflect the 'shared decision model' of a therapeutic relationship as posited by Kelner (2000) based on a shared approach to healing. In this model the role of the practitioner is to use their knowledge to assist the client or service user to be involved in the treatment drawing on the clients/service users' experiences of their health issue. Furthermore, participants' experiences support Sointu's (2006) suggestion that CAM users consider that the kind of health offered through embodied alternative and complementary health practices gives rise to feelings of control, empowerment, and agency. However, participants in this study also demonstrated a clear sense in which they did not want their clients or service

users to become dependent, nor to come only when they felt well. Furthermore, although some clients wanted to come to 'get fixed', many were keen to work with their Shiatsu practitioner in order to understand themselves and their bodies better. In contrast, Sharma (1991) noted that some participants in her study described their clients as people who – although deriving support from the therapy – did not sincerely want to get better and wanted to cling to their illness.

Although Sharma (1992) suggests that there may be a tension between an 'egalitarian ethic' of CAM practitioners seeking to espouse a person-centred approach and a claim to special professional knowledge, Long (2009) argues that practitioners may fulfil the role as teacher and consultant alongside that of healer; in other words seeing Shiatsu as 'education'. However, he suggests that, although clients were 'overwhelmingly' positive about their relationship with the practitioner, this might have been a consequence of clients wanting to be supportive to the practitioner (Long 2009, p. 4).

In summary, Part 1 has considered three key turning points in respect of the sociology of the professions – the Medical Registration Act (1858), the medical counter-culture period during the 1960s-1970s and professionalisation of Shiatsu – and related these to participants' experiences.

Although other turning points have occurred which have undoubtedly moved the field of CAM forward as discussed Chapter 2 – for example, the shift in the position of the BMA in the publication of its second report (BMA 1993), the House of Lords report (2000) and the formation of the CNHC in 2010 – these turning points have not led to Shiatsu being a fully-fledged profession. Thus Shiatsu – along with other CAM practices – remains in the margins in the arena of mainstream 21st century health care. I argue that what counts as legitimate knowledge remains a key issue and will be discussed further below.

Nearly 25 years ago, Cant and Calnan's (1991) study raised the question of the extent to which professionalisation strategies might be successfully used by practitioners in terms of how they might carve out positions for themselves *within* the scientifically dominated medical model. Although, in some cases, the value of Shiatsu training appeared to be associated with gaining a qualification, affording some sort of credibility and legitimacy, the extent to which it is possible to work as a Shiatsu practitioner inside as well as outside mainstream health care is still fraught with many of the same challenges facing Shiatsu practitioners 25 years ago.

I suggest that Etienne Wenger-Trayner's theories of social learning provide a useful theoretical framework from which to examine this issue.

Part 2 Wenger-Trayner's theories of social learning

In this second part, I focus on the specific components of Wenger-Trayner's theories which have proved especially useful in making sense of my data. In the first section I discuss Wenger-Trayner's concept of a landscape of practice and how this is relevant in the context of professional occupations. In the next section entitled 'A healthcare arena', I relate Wenger-Trayner's notion of a landscape of practice to my study and depict a landscape of practice in respect of how participants identified their Shiatsu practice in the context of a wider healthcare arena.

Professional occupations as landscapes of practice

In this section I discuss what is meant by a 'landscape of practice' and how professional occupations can be seen in this context. Etienne Wenger-Trayner's notion of a landscape of practice stems from his theories of social learning and concept of 'communities of practice'. First I outline Wenger's (1998) model of

social learning and then discuss the key components of his concept of a community of practice.

Premised on the assumption that a central aspect of learning is that humans are social beings, Wenger (1998) argues that knowledge is a matter of historically and socially defined competences with respect to valued (in the sense that they are worth pursuing) enterprises; knowing is therefore about displaying or participating in pursuit of these competences through actively engaging in social communities; meaning is the ability to experience and engage in the world as meaningful. Thus, Wenger (1998) argues that learning is a social and dynamic process in which people actively participate; furthermore, learning is meaningful and shapes identities.

Central to Wenger-Trayner's theory of social learning is the dynamic relationship between four elements – practice, social community, meaning and identity – which form the basis of his broader conceptual framework 'communities of practice' (Wenger 1998). Wenger (1998) suggests that 'practices' are a way of talking about the shared valued enterprises or endeavours associated with a 'body of knowledge'. He sees 'social communities' as social configurations in which the valued enterprise is recognisable (Wenger 1998). Actively participating in practices shapes identities which he argues is a 'way of talking about who one is meaningfully', both individually and collectively (Wenger 1998). Wenger (1998) argues that communities of practice are ubiquitous and integral to the social world, such that everyone belongs to several communities of practice at any given time – for example, within the family, in the workplace, socially. Furthermore, communities of practice are 'so informal and so pervasive that they rarely come into explicit focus, but, for the same reason, they are also quite familiar' (Wenger 1998, p. 7).

Although several people might share a valued enterprise and body of knowledge, it is possible that they could belong to the same community of practice without knowing each other. However, not all communities – for example, neighbourhoods – are communities of practice because the crucial aspect of a community of practice is *sustained interaction* and the development of a *shared repertoire* of resources: experiences, stories, tools, ways of addressing recurring problems – in short, a *shared practice* (Wenger-Trayner 2015, my emphasis).

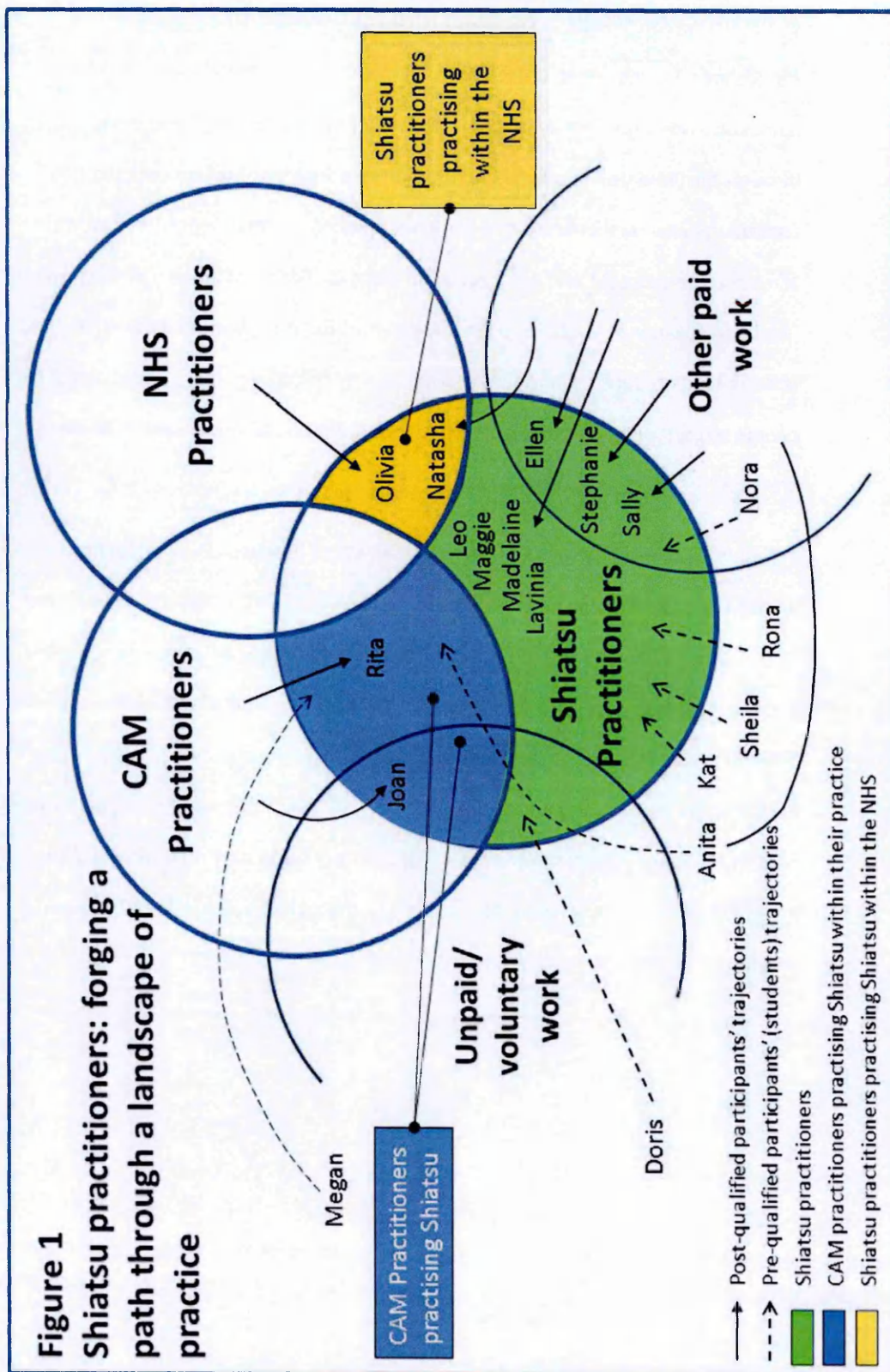
Practitioners, therefore, can usefully be viewed as forming a community of practice. However, Wenger-Trayner et al. (2015) argue that employing the notion of a single community of practice misses the complexity of most bodies of knowledge and point out that the ‘real body of knowledge is the community of people, who contribute continued vitality, application and evolution of practice’ (p. 13). As such, a ‘body of knowledge’ is best understood as a ‘complex system of communities’ including the boundaries between them and which collectively constitute ‘landscapes of practice’ (Wenger-Trayner et al. 2015, p. 13). Thus, Wenger-Trayner et al. (2015) suggest that professional occupations are constituted by a complex landscape of different communities of practice. Crucially this involves a set of active and dynamic processes.

Thus, I suggest that practitioners of Shiatsu are theoretically members, not just of the Shiatsu community, but also of the larger community of CAM practice, and, additionally, the broader healthcare arena; therefore, it is in this broader sense that they form a landscape of practice. In the next section I further develop Etienne Wenger-Trayner’s notion of a landscape of practice in relation to trajectories and shaping identities. Specifically I depict how my participants identify themselves as Shiatsu practitioners in a landscape of practice.

A healthcare arena – Shiatsu in a landscape of practice

As Wenger-Trayner et al. (2015) note, a trajectory or path through a social landscape does not merely involve acquisition of knowledge; it shapes identities through accumulated memories, competencies, key formative events, stories, aspirations and relationships to people and places. In other words, the journey 'incorporates the past and the future into our experience of identity in the present' (Wenger-Trayner et al. 2015, p19). I argue that Etienne Wenger-Trayner's notions of landscapes of practice provide a way of looking at my participants' life course experiences and their pathways through a social landscape to Shiatsu practice.

In Figure 1, I have portrayed three communities of practice as constituting a landscape of practice in relation to a healthcare arena using Wenger-Trayner et al.'s (2015) notion of 'lily pads' (p. 2). The three communities of practice within this landscape of practice include: NHS practitioners, CAM practitioners and Shiatsu practitioners. The landscape is not to scale; it includes two other areas (depicted as part-circles) which are not communities of practice (because there is no shared endeavour) that indicate other paid work and non-paid work. Other paid work refers to other work participants undertook to support their Shiatsu practice.



The way I have portrayed this landscape of practice is not to suggest that each of these three communities of practice can be isolated as single entities for, as discussed in Chapter 2, Bucher and Strauss (1961) highlight complexity in relation to competing segments. Rather, I have used the concept of a community of practice for the purpose of highlighting how practitioners viewed their identity. These positions are outlined in the sub-section below.

Positioning participants in a landscape of practice

As discussed in Chapter 5, Part 1, ('Positioning their practice'), analysis of qualified participants' accounts suggested three groups in relation to how participants positioned (or imagined in the case of students) their Shiatsu practice: (1) those participants who identified themselves as *Shiatsu practitioners* whether in private practice or practising on a voluntary basis, (2) participants who were practising Shiatsu as part of their suite of complementary therapies and who saw themselves as *CAM practitioners* and (3) participants who perceived their identity as that of a *Shiatsu practitioner in an NHS setting*. The students' imagined trajectories broadly reflect these three groupings.

I have mapped these three groups and their respective pathways to the landscape of practice as depicted in Figure 1. Furthermore, I have indicated the positions of each qualified participant in relation to the way they identified themselves individually as practitioners. Additionally, I have indicated participants' trajectories to practice (as solid arrows) in relation to the three communities of practice and other work. I have included students' positions and their imagined trajectories into practice (dotted arrows) as discussed in Chapter 5, Part 1 ('Students' imagined trajectories into practice').

Group 1 – green area, Shiatsu practitioners

As indicated in Figure 1, the green area relates to participants who identified (or envisaged, in the case of students) themselves as *Shiatsu practitioners* either in private practice or practising on a voluntary basis (group 1 above). As discussed in Chapter 5, Part 1 ('Running their own clinics and doing other paid work'), some participants were supporting their practice through doing other paid work as illustrated by Ellen, Stephanie and Nora.

Group 2 – blue area, CAM practitioners practising Shiatsu within their CAM practice

The blue area in Figure 1 includes those participants who identified themselves as CAM practitioners and who incorporated Shiatsu into their CAM practice. As discussed in Chapter 5, Part 1 ('CAM practitioners – using Shiatsu to broaden their therapy belts'), although not made explicit in Figure 1, Rita earned her living through her CAM practice whereas Joan was practising mainly on a voluntary basis.

Group 3 – orange area, Shiatsu practitioners practising Shiatsu within the NHS

The orange area indicates those participants who identified themselves as Shiatsu practitioners practising within the NHS. Although not made explicit in Figure 1, but as discussed in Chapter 5, Part 1 ('Shiatsu practitioners within the NHS'), these two participants were being paid as Shiatsu practitioners by the NHS. I will discuss their position and experiences further in Part 3 below under the heading of 'Marginalisation'.

Thus, Figure 1 draws together the themes discussed in Chapter 5 (Part 1) in relation to how participants' positioned their Shiatsu practice. Additionally, Figure 1 highlights how Shiatsu links to the wider healthcare arena and participants

identified their practice in this respect. Significantly, it reveals the tension of how participants sought to earn a living through Shiatsu in a scientifically dominated healthcare arena. This is particularly highlighted at the space at the very centre of Figure 1 – the overlap between all three communities of practice – which represents the *possibility* of a practitioner practising Shiatsu and other CAM therapies *with or within* the NHS.

However, as Wenger-Trayner et al. (2015) suggest, crossing a boundary between communities of practice, involves the question of how the perspective of one practice is relevant to that of another. As argued earlier at the end of the section under the heading ‘Shiatsu as education’, what counts as legitimate knowledge remains a key issue in keeping healthcare practices such as Shiatsu in a marginalised position. Thus, as discussed in Chapter 2, Part 1 (‘Occupational socialisation’) the issue is highly political in how it relates to coercive power and the ability to persuade the state that the specialised body of knowledge underpinning Shiatsu is of value to the public (Freidson 2001).

This tension, in the context of knowledge, will now be discussed further.

Part 3 Pathways to practice

So far in this discussion I have argued first (Part 1), that participants’ experiences related to three key turning points in respect of the sociology of the professions, and second (Part 2) that participants’ pathways to practice constitute a landscape of practice. In this third part, I draw further on the work of Wenger-Trayner to examine more closely not only what appeared to be so compelling to participants in drawing them to Shiatsu but also the resistances they encountered in relation to practising Shiatsu in a healthcare arena dominated by scientific knowledge. First, I consider participants’ pathways to practice in relation to Lave and

Wenger's (1991) notions of apprenticeship and how they reconceptualised this notion to become 'legitimate peripheral participation', relating this to my participants' experiences. In the second section, I examine how Wenger-Trayner refers to competence as 'dimensions of knowing' and how this helps to understand what served to 'pull' participants into communities of practice. I then discuss Wenger-Trayner's concept of 'knowledgeability' and use this to examine the challenges of practising Shiatsu. In the final section, I return to the issue of marginalisation and draw links between Wenger-Trayner's theories of 'peripherality' and marginalisation and neo-Weberian theory.

Legitimate peripheral participation and apprenticeship

This section examines Lave and Wenger's (1991) theories of apprenticeship which have relevance to my study in the context of entering a community of practice particularly in relation to conceptualising people as 'newcomers' and 'old timers'.

... through the changing forms of participation and identity of persons who engage in sustained participation in a community of practice: from entrance as a newcomer, through becoming an old-timer with respect to new newcomers, to a point when those newcomers themselves become old-timers. Rather than a teacher/learner diad, this points to a richly diverse field of essential actors and, with it, other forms of relationship of participation ... (Lave and Wenger 1991, p. 56)

Lave and Wenger (1991) took issue with a 'narrow reading of apprenticeship as if it were always and everywhere organised in the same ways' (p. 62). By examining different contemporary forms of apprenticeship, Lave and Wenger (1991) argued that learning or failing to learn in apprenticeship could be accounted for by underlying relations of what they termed 'legitimate peripheral participation' (p. 63). Distilled from their ethnographic studies on apprenticeship, Lave and Wenger (1991) articulated what it was about apprenticeship that seemed to them to be so compelling and which related to the transformative

possibilities of being and becoming complex, full, cultural-historical participants in the social world. It was through this focus that they first argued how learning involves participation in communities of practitioners and in order for newcomers to move toward full participation in the sociocultural practices of a community, required a mastery of knowledge and skill. Lave and Wenger (1991) generated the concept of 'legitimate peripheral participation' to characterise this kind of learning and broadened the traditional connotations of apprenticeship from a 'master-student or mentor-mentee relationship to one of changing participation and identity transformation in a community of practice' (Wenger 1998, p. 11). Essentially, the term captures the conditions under which people can become members of communities of practice. In this way a community of practice is acting as a 'living curriculum' for the apprentice (Wenger-Trayner 2015).

Thus, Lave and Wenger (1991) characterised the process as 'legitimate peripheral participation' by which newcomers (apprentices) enter a community of practice of 'old timers' (p. 56). The main point that Lave and Wenger (1991) were keen to emphasise was that, on entering a community of practice, the learning that newcomers (apprentices) were required to engage with was mediated and modified through various forms of participation.

They described two kinds of modification in this respect. First, 'peripherality', which describes some kind of exposure for newcomers to the actual practice in a community of practice. Second, for newcomers to be able to achieve an inbound trajectory into the community or practice, they need to be granted sufficient acceptability or 'legitimacy' which is designed to open the practice to non-members. Thus 'legitimate peripheral participation' provided a way of understanding the relations between newcomers and old-timers and the process by which newcomers become part of a community of practice toward full

knowledgeable participants in a sociocultural practice (Lave and Wenger 1991). I suggest that a particular strength of my thesis, which again relates to the range of participants in my study, is how this spread allowed me to compare the experiences of old-timers with newcomers in the context of legitimate peripheral legitimisation.

Furthermore, I suggest that Lave and Wenger's (1991) notions of viewing apprenticeship as legitimate peripheral participation, provide a different lens through which to examine the apprenticeship models (Cant 1996) as discussed in Chapter 2, Part 2 ('Early training courses – charismatic leaders'). Thus, the charismatic personalities associated with CAM, who attracted followers represent the old-timers in as much as they already had the historically and socially defined competences with respect to the valued enterprise of Shiatsu. In this sense, these leaders represent a 'living curriculum' (Wenger-Trayner et al. 2015) associated with a community of practice.

Thus, prior to the professionalisation of Shiatsu, Leo and his contemporary colleagues' inspirational encounters with Shiatsu through workshops and other Shiatsu-related events can be viewed as peripheral legitimisation. Furthermore, legitimate peripheral participation – in the way that Leo and colleagues came together to teach each other – became the vehicle for professionalisation of Shiatsu when they formed the Shiatsu Society (UK) and, in the sense of being a shared endeavour, arguably became a community of practice. I also argue – as evidenced through the more recent experiences of newly recruited Shiatsu practitioners that I interviewed – that peripheral legitimate participation remains a significant influence in some participants' pathways to practice. For example, as newcomers to Shiatsu, their experiences of retreats and other Shiatsu related events, provided exposure to Shiatsu (peripherality) and sufficient acceptability

by old-timers (legitimacy) to participate in the sociocultural practice of Shiatsu as a shared, valued endeavour. Not only were participants' experiences of legitimate peripheral participation in relation to Shiatsu often the first stage in their journey toward Shiatsu but they also constituted an important turning point.

Although some participants signed up for Shiatsu training with little experience or knowledge of Shiatsu, I suggest that they still experienced some degree of legitimate peripheral participation, albeit in some cases amounting to little more than a conversation with a course director. However, legitimate peripheral participation is insufficient to account for the continuing in-bound trajectories of participants into the community of practice of Shiatsu. There was a further 'pull' or 'draw' for participants which related to the knowledge associated with the Shiatsu community of practice.

The 'pull' of dimensions of knowing

Wenger-Trayner et al. (2015) suggest that competence describes the 'dimensions of knowing' negotiated and defined within a community of practice (p. 14). Thus competence includes a social dimension and is also recognisable by members of the community of practice. Dimensions of knowing are not static, but involve, instead, a constant interplay in interaction with experiences of the members of the community and Wenger-Trayner et al. (2015) argue, it is the 'regimes of competence' that serve to 'pull' people into a community of practice. In other words, people are attracted to the dimensions of knowing of a community of practice because it is meaningful to them. However, learning in a community of practice which involves a process of alignment and realignment between competence and experience, also eventually allows a claim to competence (Wenger-Trayner et al. 2015).

Thus, to become competent, it is necessary for people's knowledge and experience to become transformed through their engagement and alignment with the 'dimensions of knowing' until their knowledge and experience reflects that of the community of practice (Wenger-Trayner et al. 2015).

I suggest that the 'pull' of the dimensions of knowledge of Shiatsu may be used to explain how participants were 'pulled' toward the community of practice of Shiatsu by the body of knowledge underpinning Shiatsu. Participants' experiences in this respect not only supported their own health but also underpinned their motivation to sign up to Shiatsu training. In this sense, participants were aligning their experiences and philosophical ideas with the dimensions of knowing associated with Shiatsu theory and practice.

Within a landscape of practice, although members may not be competent in all the practices of the associated communities, they may still be knowledgeable about the other practices. Knowledgeability may be both a potential resource as well as a tension, as discussed in the next section.

Knowledgeability

Wenger-Trayner et al. (2015) refer to the complex set of relations that people build both with a community of practice and across the landscape as 'knowledgeability' (p. 13). Knowledgeability is derived from a combination of three modes of identification: engagement (direct experience of learning the competence); imagination (how people imagine themselves from different perspectives and reflect on their current position and explore new possibilities) and alignment (a two-way process of co-ordinating competencies and experiences).

Knowledgeability also establishes people as 'reliable sources of information' or 'legitimate providers of a service' (p. 23). Becoming a practitioner, Wenger-Trayner et al. (2015) argue, is best understood not as 'approximating a reified body of knowledge but as developing a meaningful identity of both competence and knowledgeability in a dynamic and varied landscape of relevant practices' (p. 23).

However, most participants in this study experienced a tension between on the one hand the excitement and what felt like a compelling body of knowledge in relation to the traditional Eastern theories underpinning Shiatsu, and on the other hand the sense that they might be perceived as 'flaky' as these ideas were not accepted by mainstream health care. As discussed in Chapter 2 ('Legitimation of knowledge and professionalisation') this can be perceived as a tension between two different epistemological worlds in relation to scientific and what might be perceived as non-scientific knowledge (Cant 1996). There are two significant aspects to this tension: first in relation to different styles of Shiatsu and second, the challenges experienced by participants associated with explaining Shiatsu. The latter manifested as a particular issue when explaining Shiatsu to potential clients as discussed in Chapter 5, Part 2, 'Shiatsu – is it a dog? It could be flower arranging!').

Different styles of Shiatsu – the role of imagination

As discussed in Chapter 4, Part 5 'Shiatsu as a vast toolbox', some students felt more secure and found Shiatsu more rewarding when they began to develop their own style of Shiatsu. I suggest that in the context of Wenger-Trayner et al.'s (2015) notions of knowledgeability this relates to the role of imagination in transformative possibilities. In other words students are using their imagination to

combine their knowledge of Shiatsu and other experiences to explore new possibilities.

Furthermore, one of Wenger's (1998) key points about formalised training programmes which involves attendance at classes, requires memorising information and taking examinations in order to gain accreditation. Wenger (1998) argues that the learning that is most personally transformative – despite the curriculum, discipline and exhortation of teachers – is the learning that involves and derives from informal membership of communities of practice. Thus, I suggest that in this study, the informal spaces of learning provided by for example, placements and support groups which appeared to have helped participants not only to progress in their training but also move their practice forward, supports Wenger's (1998) point in this respect in that participants' learning was most transformative through these experiences.

However, as Wenger et al. (2015) note, members of a community have their own experience of practice, which may 'reflect, ignore, or challenge the community's' current regime of competence (Wenger-Trayner et al. 2015, p. 14). This view is reflected in Sharma's (1992) assertion that practitioners are likely to develop their own ideas in the course of their practice and furthermore that this intellectual autonomy 'bedevils' attempts to achieve professional unity (p. 124). Indeed as discussed in Chapter 5, Part 2 ('Shiatsu – is it a dog? It could be flower arranging!'), the most long-standing participant argues that Shiatsu is a 'whole zoo' and that 'Shiatsu is an umbrella term' for a whole range of different styles that exist and compete under the title of Shiatsu. I suggest that the emergence of the variety of styles of Shiatsu and their associated names can be understood using Wenger-Trayner et al.'s (2015) notions of knowledgeability in how

members of a community realign their dimensions of knowledge using their experience.

Furthermore, these different styles potentially give rise to new communities of practice and thus a new landscape of practice, reflecting the dynamic ever-changing environment of the landscape. Additionally, as discussed in Chapter 4, Part 5 ('Quality of touch'), the way Leo argues for a change to the Shiatsu Society baseline syllabus to be 'reformulated to be a proper curriculum with learning outcomes' based on the 'quality of touch', reveals possible divisions in the Shiatsu Society (UK).

This perspective brings to the fore how communities of practice are far from havens of peace (Wenger 1998). Furthermore, I suggest that the different styles of Shiatsu reflect Bucher and Strauss' (1961) notions of segmentation in how different groupings compete and jostle for positions within a profession. This segmentation is also reflected in the landscape of practice depicted in Figure 1, as discussed earlier, not only in the three different ways that participants identified themselves as practitioners but also in the three communities of practice (Shiatsu, CAM and NHS practitioners).

Perhaps in an even broader landscape of practice, in the context of the development of Shiatsu in Japan (as discussed earlier), although the name *Shiatsu* literally means 'finger pressure' it came to mean any number of methods without pointing to any one in particular (Kishi and Whieldon 2011). However, in Japan, the name *Shiatsu* is culturally understood whereas in the UK, the name is not only unfamiliar but has little if any historic or cultural meaning. Thus, although different styles of Shiatsu developed in Japan, the term Shiatsu still had sufficient cultural significance for it to remain meaningful as a therapy. Similarly, I suggest that although in Japan there was an attempt to align Shiatsu with a more

scientific framework of knowledge, the fact that it was already culturally embedded enabled it to remain understood by the Japanese people.

In the next section I discuss the challenge of explaining Shiatsu which, as indicated above, is the second manifestation of the tension in relation to the status of knowledge in the context of knowledgeability.

Explaining Shiatsu – the role of alignment

In contrast to how Shiatsu was culturally embedded in Japan, when Shiatsu purportedly arrived in the UK around the early part of the 1970s, it lacked any kind of cultural significance. Therefore competing for a position in a healthcare arena dominated by scientific knowledge meant in effect it was starting from the beginning with no advantage. The corollary of this situation meant there was an associated difficulty in explaining Shiatsu to UK people with little or no experience of Japanese culture and – as evidenced in this study – this difficulty still remains a significant challenge.

As discussed in Chapter 5, Part 2 ('Shiatsu is it a dog? It could be flower arranging!'), by way of a strategy to overcome this issue, participants felt obliged, despite a reluctance to do so as it belied the theory of Shiatsu, to draw on other more well-known and possibly accepted bodies of knowledge to explain Shiatsu, for example Physiotherapy and Acupuncture. In this sense, I suggest that what participants are doing is modulating the identity of Shiatsu by aligning their knowledge of Shiatsu to other dimensions of knowledge that are culturally better understood. In effect although they are perhaps masking its cultural roots – expressed in their discomfort and dissatisfaction at finding it necessary to explain Shiatsu in this way – their aim is to give credibility to Shiatsu. Thus I suggest that the codified body of knowledge – developed as a consequence of the professionalisation of Shiatsu and designed to give it credibility – described the

dimension of knowledge or competence as defined by the Shiatsu community of practice. Crucially, I argue that in effect this body of knowledge provided little more than an 'uneasy partnership' between the more Western-based anatomy and physiology and Eastern knowledge in relation to the theories of Shiatsu.

This difficulty relates not just to the credibility and acceptance by mainstream health care but also by potential clients.

Clients experiencing peripheral engagement

As discussed in Chapter 5, Part 2 ('Marketing strategies to attract clients'), advertising was not regarded by participants as an effective way to build up a clientele. Rather, word of mouth which was based on clients' experience of Shiatsu was the chief means by which people became aware of practitioners, and this supports Sharma's (1992) finding. Thus gaining clients in this way is linked to the satisfactory experiences of existing clients and trusting the practitioner (Sharma 1992, Fulder 1996). In relation to knowledgeability, existing clients are thus acting as reliable sources of information based on their engagement with Shiatsu. As discussed earlier, participants' experiences of Shiatsu at retreats or other experiential events were transformative in the sense that these experiences led to their becoming practitioners. I suggest that in the same way it is possible that where clients' experiences of Shiatsu enable feelings of control, empowerment and agency, this could be explained as experiencing peripheral engagement through their exposure to practice.

Thus although the dimensions of knowledge underpinning Shiatsu practice help to understand what served to 'pull' some participants into the community of practice of Shiatsu, it also exposes the tension associated with the status of this knowledge in relation to scientific knowledge. This tension highlights the issue that Shiatsu is a healthcare practice with little cultural meaning which in turn

makes it difficult to explain, particularly in a mainstream healthcare arena grounded in scientific knowledge. Thus participants used their knowledgeability of other more well-known healthcare practices to enhance the credibility of Shiatsu in order to attract clients.

I argue that this lack of credibility or critical level of acceptance within the UK healthcare arena, means there is marginal scope for practising Shiatsu.

Marginalisation

In this final section of this part, I argue that the issue of marginalisation provides a connection between the theories of Etienne Wenger-Trayner in relation to landscapes of practice and neo-Weberian theory as posed by Mike Saks, in relation to CAM practices. Furthermore, the issue of marginalisation highlights some of the wider structural factors, for example the interface of Shiatsu with the NHS and other CAM practices as well as society in general.

As discussed earlier, the key point of the neo-Weberian perspective in respect of CAM, as argued predominantly by Mike Saks, is to demonstrate the effective marginalisation of the diverse array of CAM practices to a position outside of statutory healthcare provision. Shiatsu provides a specific example in this respect. From a Foucauldian position, the power to marginalise stemmed from how scientific knowledge was considered to be the dominant form of knowledge. Not being able to demonstrate efficacy based on a scientific body of knowledge therefore marginalised Shiatsu practice as a legitimate form of healthcare practice. Effectively, scientific knowledge is what binds mainstream health care despite its complexity; thus scientific knowledge constitutes the 'shared endeavour' in relation to a community of practice of mainstream health care.

Resistance to the acceptance of newcomers on the part of members of communities of practice raises issues of power (Lave and Wenger 1991, Wenger 1998, Wenger-Trayner et al. 2015). Wenger-Trayner et al. (2015) argue that the landscape(s) of practice comprising complex systems of communities also includes the boundaries between them. Boundaries and peripheries are interwoven as illustrated graphically in Figure 1.

Thus peripherality is an ambiguous position in that it can represent both the possibility of access to a practice or where outsiders are marginalised and prevented from entering (Wenger 1998). Wenger (1998) perceives that there is no distinct line between peripherality and marginality and refers to marginalisation as a form of non-participation which prevents full participation. I argue that it is specifically this conceptualisation of marginality in relation to power that connects Wenger-Trayner's theories to neo-Weberian theory.

Although there were incidences of CAM practitioners working within the NHS when she undertook her study, none of Sharma's (1992) recruits were in this position and therefore she was unable to explore this aspect of CAM practice. In contrast, two of my participants identified themselves as Shiatsu practitioners within an NHS setting and the experiences of these two participants provided a valuable contrast to those participants practising outside of the NHS. For example, and as discussed in Chapter 5, Part 2 ('Charging strategies'), the complex issues around asking for a direct payment and attracting clients did not apply to the two participants working within the NHS.

However, the focus of this final section is to examine in more detail, the strategies by which these two participants succeeded in practising Shiatsu (a practice marginalised by mainstream health care) within the NHS in relation to Wenger-

Trayner et al.'s (2015) notions of knowledgeability and the complex interactions on the borders of communities of practice.

Gaining access involved a complex set of processes. Although serendipity played a part, there also appeared to be some sympathy for and recognition of the benefit of Shiatsu by gatekeepers, for example budget holders and other teams (where Occupational Therapy and Physiotherapy appeared to be significant). However, I suggest that successful entry was most closely associated with the way participants adapted to the dimensions of knowledge; in other words how they engaged and aligned with existing policies and practices within the community of practice of the NHS (whether entering from without or within). Wenger-Trayner et al. (2015) refer to this kind of knowledgeability as 'modulation of identification' in which practitioners negotiate their role and perform an 'improvisational dance' (p. 25). Thus participants' successful access depended on being seen to act competently and trusted as a practitioner and being held to account where necessary. As such, although not disputing the benefits as perceived by the participants, I suggest that being able to practise Shiatsu within the NHS was not about its efficacy (based on scientific knowledge) but about a willingness to fit in and, crucially, using their knowledge of how to be seen to act competently. In other words, in order not only to gain access but also become and remain accepted, they needed to ensure that they aligned their practice to the dimensions of knowledge of the particular area they entered.

Furthermore, once through the 'mainstream gateway' and into the community of practice associated with mainstream health care then participants appeared to have a fair degree of autonomy provided they abided by the policies and practices of the given NHS setting. Additionally, participants' experiences suggested that they were accepted as credible members of teams and their

accounts would appear to indicate that service users benefited from Shiatsu treatments.

This opens up the question of how Shiatsu could be delivered more widely within the NHS. Furthermore, it draws attention to the extent to which it would be possible to develop a career within the NHS rather than in private practice. I argue that these questions highlight ways in which Shiatsu may have a potential for addressing social inequalities, a criticism often aimed at privately practising CAM therapists operating outside the NHS. More research is needed in this area in a UK context.

In Part 3, I have examined participants' pathways to practice drawing on Wenger-Trayner's theories in relation to legitimate peripheral participation. I have argued that participants' peripheral engagement as newcomers and the influence of charismatic leaders remain important factors in some participants' pathways to practice. Furthermore, I used Wenger-Trayner's notions of dimensions of knowledge to argue that not only do these serve to 'pull' people toward Shiatsu but also, through identification and alignment of their experiences and ideas with the practice of Shiatsu, they use their knowledgeability to develop their own style of Shiatsu. Critically, however, I have argued that what counts as legitimate knowledge remains a key issue in keeping Shiatsu as a marginalised practice through not being able to demonstrate its efficacy through scientific knowledge. I have drawn on Wenger-Trayner's concept of knowledgeability to explicate how participants managed the tension between the uneasy partnership of knowledge underpinning Shiatsu and that of mainstream health care. In the final section, I drew together the theoretical perspectives of the two key theorists – Mike Saks and Etienne Wenger-Trayner – to focus on the issue of marginalisation through an examination of the experiences of participants practising Shiatsu in the NHS.

Before bringing my thesis to an overall conclusion, I pause below to reflect on my experiences in relation to my journey into Shiatsu practice and how this led to becoming a researcher in the field of my practice.

Part 4 Reflections on a landscape of practice – researcher and Shiatsu practitioner

In this penultimate part of the chapter, I reflect on my experiences of entering and being in a landscape of practice in relation to my position as both researcher and Shiatsu practitioner. In the first section I reflect on my journey into Shiatsu which began over 10 years ago, drawing on an article (Spurr 2005) that I wrote around that time, and compare my experiences with those of my participants. I then consider my journey as a researcher in the field of my practice, reflecting on the most significant challenge associated with this process – how to use my knowledge of the field yet ensure that I suspended my preconceptions.

My journey into Shiatsu

Like other participants in my study, it was a health issue – in my case migraines – that led me to Shiatsu. However, in contrast to my participants, Shiatsu came to me through a work colleague who practised Shiatsu:

In 'mid-migraine' one day at work trying to focus and wondering if I should give in and take a painkiller, my colleague, Jo³⁸, sensing my distress, offered to do some 'Shiatsu' on my feet. Although I knew her as a trusted friend I knew nothing about Shiatsu. However, I was in such pain that I was quite prepared to give it a go ... I was acutely aware of how profound the effect of working on my feet had been on my migraine; I will never forget that moment. If 'Shiatsu' could provide relief from the attacks of migraines even if it didn't prevent them this was worth pursuing! ... (Spurr 2005, p. 394)

³⁸ Pseudonym

In a similar way to how some participants spoke about their experiences during retreats, this experience had quite a profound effect on me. I was also very aware that there was something about Jo – a charismatic quality – that had sparked an intense curiosity in me to find out more.

However, my background in science left me questioning the extent to which it was possible to understand something that I could neither see nor measure. I found it hard to make sense of the abstract notions of 'Chi' and 'meridians' yet the concepts intrigued me. My experiences resonate very much with Maggie's in this respect.

I remember thinking that although it seemed very likely that Shiatsu would benefit me, more importantly, I needed to know that it would not harm me. I realised that whether or not I could trust Jo linked closely to the issue of how risky this treatment seemed to me. I started going for regular Shiatsu sessions. The way Rona spoke about trusting her therapist reminded me of the way I felt I could just instinctively trust Jo.

Moreover I felt that I was beginning to take part in my own healing and I valued this. However, unfortunately Jo left the area and although I recognised that it might benefit me to try to keep going with Shiatsu, I was now presented with a problem of how to find another practitioner. I began to search for another Shiatsu practitioner and started researching via the internet for local practitioners. It had to be the right person.

At this time, in my role as a Curriculum Manager at The Open University (OU), I was working with a team of academics to produce a course that aimed to examine issues associated with CAM in the context of the social, political and cultural influences that shaped people's health. This experience was an important influence in the next phase of my journey as it sparked an interest in what might

be involved in Shiatsu training. Out of curiosity I began scanning the sites associated with Shiatsu training schools. I wondered how people who wanted to train as practitioners knew how to choose between Schools when, just as some participants in my study found, it all seemed very confusing (not to mention expensive). My motivation to sign up to train in Shiatsu was very much associated with a desire to learn about the ideas underpinning Shiatsu which intrigued me greatly. Unlike some participants in this study, the qualification itself was not the draw for me.

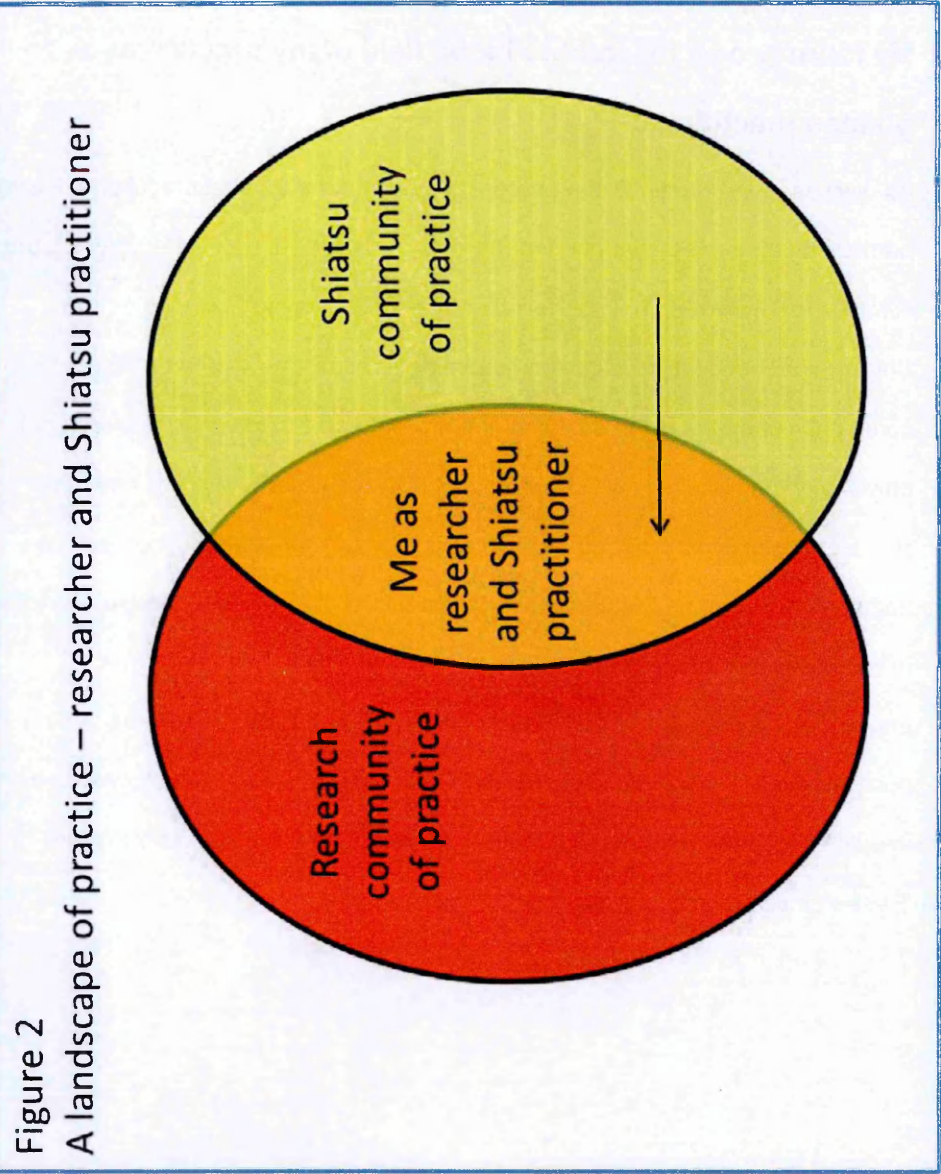
After completing my training, which included achieving MRSS status, I began to practise Shiatsu at a local sports injury clinic where I had carried out my placement during training. Our family circumstances meant that I was the sole wage earner and therefore it was not a viable option for me to give up my job at the OU. Furthermore, despite finding Shiatsu rewarding, I also enjoyed my work and therefore decided to continue in my full-time position at work fitting in two or three Shiatsu treatments per month after working hours. In this sense, in relation to Figure 1, I see myself in a similar position to Ellen, Sally and Stephanie in that I identify myself as a Shiatsu practitioner rather than a CAM practitioner, doing other paid work to support my practice.

Thus, my initial encounter with Shiatsu on account of a health issue, mirrors the experiences of some of my participants. Similarly, although initially sceptical, my deepening curiosity about Shiatsu 'pulled' me toward its body of knowledge enticing me to sign up to train and, like other participants in my study, I found it fascinating. However, unlike some participants who were pragmatically seeking a qualification, this was not the case for me. It was not the qualification *per se* that drew me; rather it was the ideas behind Shiatsu that I found were important to me and that I knew how to practise safely.

In the next section I consider how I used this knowledge and experience of Shiatsu to become and being a researcher in the field of my practice as a Shiatsu practitioner.

My journey as a researcher in the field of my practice as a Shiatsu practitioner

As discussed in Chapter 2, the process of becoming a Shiatsu practitioner – and particularly the project that I undertook in my final year of training – provided the stimulus for my research. I suggest that in a similar way to how I joined the Shiatsu community of practice, on becoming a researcher I joined a research community of practice – that is a community of people involved in research not only within the Faculty in which I work, but also the wider University and other research settings outside of the University, including for example, conferences and seminars. I argue that these two communities of practice – Shiatsu (depicted in yellow) and research (depicted in red) – essentially form a landscape of practice as depicted as two 'lily pads' (Wenger-Trayner 2015) in Figure 2. I position myself – as a researcher in the field of my practice – in the overlapping middle space (coloured orange). The arrow represents my trajectory into the 'Research community of practice'.



Knowledgeability and reflexivity

I suggest that this position of the middle space of overlapping relations between the two communities of practice, enabled me to have what Wenger et al. (2015) refer to as 'knowledgeability' in the sense that I became my own source of information. In other words, my direct experience of Shiatsu, first as a client, then as student and practitioner, as discussed in the previous section, enabled me to identify with others' knowledge of the competence associated with the Shiatsu community of practice. By first juxtaposing my understanding, knowledge and experiences of Shiatsu with those of my participants and then using my imagination (in the context of knowledgeability) to explore different perspectives, I was able to generate an overall analytic story.

My knowledgeability enabled me to gain access to participants. It also allowed me to have 'deep familiarity' which, as argued in Chapter 3 (Part 1), was the rationale for going into the field (Goffman and Lofland 1989). However, also discussed earlier, an important methodological consideration and the most significant challenge to using my Shiatsu experiences productively, was to ensure that I suspended my own preconceptions and experiences of Shiatsu and maintained a marginal position during the whole process of producing my thesis.

I have previously argued in Chapter 3, Part 1 ('Generating the ethnographic enterprise – reflexivity'), that my reflexivity served as the methodological tool to achieve marginality. I suggested that reflexivity involves being a foil, allowing the silences to probe sensitively and gives space for emotion. Furthermore, I argued that the skills to accomplish this are largely instinctive but also framed and underpinned by values of honesty, openness and reciprocity. Critically, I argued that these are practices I have developed as a Shiatsu practitioner and which are transferable to being a researcher.

In relation to my research, I have described the process of reflexivity as a 'methodological tool'. Although, I do not think of it as a 'methodological tool' in my practice as a Shiatsu practitioner (as discussed in my reflections in Chapter 3) I use the same kind of skills of reflexivity in my role as a researcher.

In my Shiatsu practice, listening and allowing space for my clients to 'tell' their story both through bodywork as well as conversation builds trust and enables us to work in partnership. I seek to achieve this as an important principle of my practice as a Shiatsu practitioner. When working with my clients I try to achieve a state of 'forgetfulness of self' (Bourdieu 1996, p. 24) and become 'unintentionally present' (Masunaga and Ohashi 1977, p. 55) and see this is a vital aspect of my practice as a Shiatsu practitioner.

Similarly, in my research, I reflexively used my experiences to probe and make sense of my participants' experiences, at the same time ensuring that my preconceptions did not come to the fore. For example, although perhaps an obvious aspect to note, I needed to be mindful that a health issue might not be the starting point for everyone's journey into Shiatsu nor assume that all my participants had similar experiences to mine. Equally, where participants' experiences differed to mine, I needed to ensure that I gave due consideration to their different experiences allowing these to feature in the overall analytic story.

However, in both practices as I generate the data, not only do I write it down, I also think about it and then I act on it. Furthermore, there is an ongoing, iterative interplay in these stages and I am constantly watchful for further clues as to ways of making sense of the data, responding to mine as well as others' ideas. In each practice, I use my reflexivity to analyse this data or information by looking for the patterns, things that stand out as unusual; it is a constantly evolving and continuing interaction.

Although I have argued that the way I reflexively interacted with the whole process which involved drawing on my skills as a Shiatsu practitioner to keep myself in the background, I also needed to avoid too passive a role; sufficient active engagement on my behalf was necessary to ensure that my reflexivity was a 'productive force' (Madden 2010).

I felt it was helpful to my participants that they knew I had some knowledge (discussed earlier in Chapter 3) which meant we could focus on their experiences rather than it be a test of their knowledge of Shiatsu. However, sometimes I felt that perhaps we had moved on too hastily and I could have probed further. Although I was tempted to go back and perhaps encourage them to explain in more detail, most participants' responses were very full and detailed and they needed little encouragement to speak in great depth. I decided that on balance, I needed to take a consistent approach and, as discussed in Chapter 3, Part 3 ('In defence of 'one-shot' interviews – a story to tell'), I have defended my decision to interview my participants once.

Thus, my 'layers of past experiences and motivations' (Sharma 1992) which drew me to Shiatsu enabled me to have deep familiarity with the field. In my position in the middle space of Figure 2, as both researcher and practitioner, I used my knowlegeability (Wenger-Trayner et al. 2015) as a foil, reflexively probing without predominating, to generate an analytic story.

In the final part of this chapter, I draw my thesis to a conclusion by summarising the key arguments, discuss potential transferability of this work outlining possible limitations, and suggest areas for further research.

Part 5 Conclusion

As discussed in the review of the literature in Chapter 2, this thesis is situated broadly within the sociology of the professions and has aimed to address the following research questions:

1. What processes are involved in becoming a Shiatsu practitioner?
2. How do Shiatsu practitioners understand and explain their practice?
3. What are the opportunities and challenges experienced by Shiatsu practitioners in relation to the professionalisation of Shiatsu?

Voyages of discovery

I have argued that the depth of Sharma's (1992) UK-based study not only provided a rich but also a methodologically comparable resource to help make sense of and discuss my findings. Therefore, although there have been other studies, Sharma's study to date remains the most relevant to my work. As noted, Sharma (1991) argues that the question 'Why do people become complementary practitioners?' can be answered on at least as many levels as the question 'Why do people use complementary medicine?' (p. 127). In this respect participants' varying 'voyages of self-discovery' as part of their individual trajectories to Shiatsu practice reflect Sharma's (1992) 'layers of past experiences and motivations'. As I have argued, the range of participants recruited in relation to both their different stages in their life course and Shiatsu practice represents a particular strength of this study. In addition, I have argued that my experiences of being a Shiatsu practitioner allowed me 'deep familiarity' with the field and thus a resource with which to examine my participants' accounts in order to produce a nuanced overall analytic story. Many of my findings mirrored not only Sharma's (1992) but also other research. For example, how health-related issues and alignment of ideas influenced participants' decision to seek Shiatsu.

However, there were three key differences between my findings and those of Sharma (1992). First, in contrast to Sharma's (1992) participants who seldom made an unpremeditated 'jump into the dark', several participants in this study signed up for Shiatsu training with no previous knowledge or experience of Shiatsu. In this respect these participants' motivations were largely pragmatic (taking up Shiatsu as part of a degree or as a change of career) in the sense that they were seeking Shiatsu as part of gaining a qualification. Second, in contrast to Sharma's (1992) study, most participants in this study were not averse to working in large organisations. Indeed, few participants appeared to have a clear sense that setting up in business was a primary objective or indeed had much by way of business knowledge. Third, none of Sharma's (1992) recruits were in the position of practising in the NHS. In contrast, two of my participants identified themselves as Shiatsu practitioners within an NHS setting and the experiences of these two participants provided a valuable contrast to those participants practising outside of the NHS.

Positioning Shiatsu practice

The significance of these differences relates to the wider structural context of earning a living through Shiatsu within a scientifically-dominated healthcare arena. A key question raised in the literature review is whether professional groups are motivated predominantly by public interest or self-interest (Stone 2002b). In this respect Sharma (1992) makes an important point when she notes that although many CAM practitioners identify with a 'professional ideal of public service, their services are only accessible to those who can pay' (p. 173). This pivotal issue is reflected in my participants' accounts of how some would prefer to be in a position where they did not charge for Shiatsu. Crucially this did not necessarily equate to giving Shiatsu away on a voluntary basis but was related to

being part of an organisation – particularly the NHS – where they would not directly charge clients for Shiatsu.

Thus I suggest that, although some participants were either already set up in business as a Shiatsu practitioner – or intending to do so – as a way of earning a living, this was not necessarily a preference. Rather it was more associated with how there were few, if any, opportunities to practise Shiatsu in any other way.

Furthermore, despite the value of a Shiatsu qualification purportedly affording some sort of credibility and legitimacy – generated through the process of professionalisation modelled on fully-fledged professions such as the medical profession – I argue that, as evidenced in this study, the extent to which it is possible to work as a Shiatsu practitioner inside as well as outside mainstream health care is still fraught with many of the same challenges facing Shiatsu practitioners 25 years ago.

As discussed in Chapter 2, a significant turning point in the Government's position in respect of CAM occurred when it acknowledged that CAM can play a part in treating NHS patients (DH 2001). However, the Government was also clear that if CAM aspired to be an equal player with other forms of NHS treatment, it must meet the same standards in terms of its evidence base, regulatory structures and diagnostic procedures (DH 2001).

Caught in a 'knowledge trap'

In this respect, critically, I have argued that what counts as legitimate knowledge remains a key issue in keeping Shiatsu as a marginalised practice through not being able to demonstrate its efficacy through scientific knowledge. Effectively, this means Shiatsu practitioners lack the coercive power and ability to persuade the state that the specialised body of knowledge underpinning Shiatsu is of value

to the public (Freidson 2001). As such, I argue that in forging a path through a landscape of practice, Shiatsu practitioners – like other CAM practitioners – are caught in a 'knowledge trap'. Consequently, Shiatsu and other CAM practices remain 'unfledged' professions.

However, as discussed in Chapter 2, where NHS authorities or Trusts are providing CAM, for example within pain clinics in hospitals, it tends to be on an ad hoc basis, not necessarily based on evidence, but as a result of strong, local advocates forging good community relationships (Heller 2005). This is clearly illustrated in my study through the two participants practising within the NHS (as depicted in Figure 1).

I have drawn on Etienne Wenger-Trayner's work in relation to theories of social learning to examine not only what appeared to be so compelling to participants in drawing them to Shiatsu but also the resistances they encountered in relation to practising Shiatsu in a healthcare arena dominated by scientific knowledge. The crucial relevance of Wenger-Trayner's work to my study is that learning – which is an essential part of professionalisation – is a social and dynamic process in which people actively participate; furthermore, learning is meaningful and shapes identities. I have argued that it was the 'pull' of dimensions of knowledge underpinning Shiatsu that attracted some participants to Shiatsu.

Furthermore, participants' legitimate peripheral participation in events such as retreats and the influence of old-timers as charismatic leaders remains a significant motivating force. Additionally, the engagement, alignment and role of imagination by participants lead to the development of different styles as well as new dimensions of knowledge within the Shiatsu community. I have drawn links to Bucher and Strauss' (1961) theories of segmentation in this respect and how

diversity and conflict of interest are a more useful representations of professions than identifying traits or commonalities.

The lens of knowledgeability

Critically, Wenger-Trayner highlights the boundaries in between communities of practice and Wenger-Trayner et al. (2015) suggest that crossing a boundary between communities of practice involves the question of how the perspective of one practice is relevant to that of another. I have drawn on Etienne Wenger-Trayner's work particularly in respect of his concept of knowledgeability – the complex set of relations that people build both with a community of practice and across the landscape – as a lens to examine the issue of how two practitioners gained access to the NHS.

Furthermore, I have drawn together the theoretical perspectives of the two key theorists I have used in my thesis – Mike Saks and Etienne Wenger-Trayner – to focus on the issue of marginalisation. I argue that the issue in relation to the status of knowledge gets to the very 'heart' of the matter.

Indeed drawing attention to the space at the very centre of Figure 1 – the overlap between all three communities of practice – represents the *possibility* of a practitioner practising Shiatsu and other CAM therapies *with* rather than *within* the NHS. A focus on this area would go beyond questions such as how Shiatsu could be delivered more widely within the NHS or the extent to which it would be possible to develop a career within the NHS rather than in private practice.

However, as discussed in Chapter 2, although Long (2008) concluded that Shiatsu may have the potential to make a cost-effective contribution to health care, as Stone (2002b) strongly argues, a therapy has the capacity to cause harm when used inappropriately, despite the assumption that it is generally

considered to be relaxing, gentle and harmless. As such, Stone (2002b) argues that NHS commissioners are necessarily cautious about working with services that are not deemed to be safe or cost effective.

Although the two practitioners in my study who practised Shiatsu within the NHS were willing to comply with or align their practice to the policies and practices of the NHS, as Stone (2009) noted the *willingness* of practitioners to register for the CNHC is not known and it would appear that it is only a minority of people who are registering. In turn this suggests that without a willingness to align their practices to the policies and practices of regulatory structures based on mainstream health care, in the words of Stone (2010), Shiatsu practitioners seeking to work with mainstream health care may find themselves 'left out in the cold' (p. 2).

Transferability and further research

Thus, as discussed above, Stone (2002a) highlights major ethical and legal responsibilities owed by CAM practitioners to their patients, namely in terms of duties to benefit and not to harm their clients. As discussed in Chapter 2, Long (2008) suggests that Shiatsu has a role in maintaining and enhancing health, and may have the potential to make a cost-effective contribution to health care in relation to, for example, tension, stress and musculoskeletal difficulties. However, in the UK the extent to which people can access Shiatsu is primarily a matter of cost (Long 2009), and in this respect marginalises people who are economically disadvantaged. In the context of the potential to deliver Shiatsu as part of mainstream health care, Pirie et al.'s (2012) study suggested that GPs welcomed having more options of care, especially for patients with complex, chronic symptoms, and patients appreciated the increased time and holistic, patient-centred approach during Shiatsu consultations. Pirie et al. (2012) concluded that

their study successfully integrated a Shiatsu clinic into a general practice and offers a model for future research on complementary medicine in primary care. To reiterate, in Europe, Shiatsu has been practiced professionally for about 40 years. While its practice is allowed under common law in the UK and Ireland, in the rest of Europe Shiatsu is tolerated, but without recognition; in no country is there integration into state healthcare systems (Long 2008).

I suggest that further research could build on the findings from my exploratory study of Shiatsu practitioners and draw together two research strands in relation to safe practice and efficacy (as outlined in the above paragraph) to investigate how Shiatsu could be delivered effectively in mainstream health care.

For example, further research might include an exploration of Shiatsu practitioners' willingness to register for the CNHC because, as noted Chapter 2, Part 3 ('Formation of the Shiatsu Society and training schools') Shiatsu practitioner membership of the CNHC represents less than 1% of the total membership of the Shiatsu Society (UK). At the time of data-generation in this study, the CNHC had only been in operation for just over a year and thus a limitation was that there was little awareness of its existence among my participants. Thus, I suggest that in an overall context of professionalisation, membership of the CNHC is an important area to explore in further research as this would help to provide a better understanding of the reasons why practitioners do not appear to be registering for this regulatory council.

In the context of practising Shiatsu within mainstream health care, although my exploratory study generated detailed data in respect of the two participants practising within the NHS, I suggest it would be useful to extend this aspect of my research to examine in-depth other cases of where Shiatsu practitioners are practising with or within the NHS, particularly in relation to safe practice. This

might, for example, build on and extend Pirie et al.'s (2012) study to explore how Shiatsu could make a cost-effective contribution to health care in primary care settings.

I have argued that the spectrum of experiences across a broad temporal dimension is a particular strength of this study. This provided an important connection to the turning points in relation to the sociology of the professions as discussed above. However, from a different methodological perspective, it would be useful to take an in-depth, case-led longitudinal (rather than cross-sectional) approach within a particular timeframe. This could include, for example, exploring the experiences of the same people from the point when they first signed up for Shiatsu training to one year, post-qualifying. Further, it would be useful to compare the experiences of students and graduates from different Shiatsu training schools.

Participants in this study tended on the whole to have a positive view of Shiatsu which, given their willingness to take part, is not surprising. Therefore it would be helpful to explore the experiences of those people who dropped out of Shiatsu training or had negative experiences of Shiatsu as this would be a valuable comparative study. Additionally it could provide the opportunity to understand why some people might choose not to practise Shiatsu as a means of earning a living which could lead to a better understanding of Shiatsu practitioners' motivations to practise and thus further knowledge of the professionalisation process.

Furthermore, the analytic framework – trajectories, turning points, social positioning and landscape of practice – could be used to examine the potential parallel experiences of other professional groups within the healthcare arena depicted in Figure 1 above. The range of professional groups within this

landscape of practice includes those that are statutorily regulated and those that are not. A limitation of this proposed transferability – in other words where it might be more difficult to apply the framework – might occur in the statutorily regulated professional groups because of an assumed greater compliance to authority. Nonetheless, the framework offers the possibility of illuminating more connections across a landscape of practice associated with statutorily regulated professional groups which might include other physical therapies such as Physiotherapy (see for example, Lindquist et al. 2010) or Osteopathy (see for example, Thomson et al. 2014).

In the context of delivering integrated health care that is safe and fit for purpose in the 21st century, the recent PSA report on the Accredited Registers programme³⁹ (PSA 2015) claims that the programme gives commissioners and employers of health care the confidence to make wider use of healthcare practitioners. Figure 1 highlights the significance of boundaries and the difficulties of working at the interfaces. I suggest that it is possible to imagine how other communities of practice in relation to healthcare practices might form different landscapes of practice reflecting the kind of integrated health and care envisioned by the PSA. Furthermore, Wenger-Trayner's concept of knowledgeability affords a practical possibility with regard to how to forge relationships across and within the boundaries between healthcare practices.

In conclusion, I suggest that the experiences of participants in this study are likely to be of relevance to practitioners, not only in emerging professions in marginalised positions but also by offering insights that may add to our understanding of the process of becoming a practitioner in more established professions. Further, I argue that the important issues raised through an

³⁹ The Accredited Registers programme was established by the Government following The Health and Social Care Act (2012) to broaden the scope of accredited registers to include those healthcare occupations not regulated by statute.

exploration of the pathways to practice forged by the participants in this study, have potential transferability to the landscapes of practice in relation to other professional occupations.

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Appendix 01

Shiatsu Society UK Baseline Syllabus

Section 12 of the Rules & Regulations states:

12) BASELINE SYLLABUS

- a) The Baseline Curriculum and Syllabus defining training needed for MRSS status by the Shiatsu Society is held as a separate document from the Rules and Regulations by the Society.
- b) Changes to this document are controlled by a sub-committee which will include at least four MRSS(T) teachers who have held the qualification for at least five years ('Experienced Teachers'). This sub-committee shall be called the Curriculum Panel. Members of the Curriculum section of the Education Sub-committee are automatically included on the Curriculum Panel.
- c) The Rules of Operation shall be ratified at the next AGM. If accepted, then the Rule changes as a whole are accepted.

12) BASELINE SYLLABUS

1) CORE THEORY

i) General

- 1) The concept of pervasiveness of Ki, within the body and throughout nature.
- 2) The concept of dynamic equilibrium of complementary forces, described as Yin and Yang.
- 3) Understanding the movement of Ki throughout the body.

ii) Meridian Tsubo Theory

- 1) Location of the classical meridians
- 2) The nature of Tsubo, e.g. their depths, responsiveness and how touch may effect them beneficially.
- 3) The location of the following list of 113 Tsubo and the common uses of the 52 Tsubo highlighted and underlined in the list.

LU	<u>1, 5, 7, 9, 11</u>	LI	<u>1, 4, 10</u>
	11, <u>15, 16, 20</u>		
ST	1, <u>3, 9</u> , 17, 25, 30, <u>36, 40, 44, 45</u>	SP	1, <u>3, 6, 9</u>
	<u>10, 15, 20, 21</u>		
BL	1, <u>2, 10, 11, 13, 14, 15, 17, 18, 19,</u>	KI	<u>1, 3, 6, 7,</u>
	<u>10, 27</u>		
	<u>20, 21, 22, 23, 25, 27, 28, 36 (50),</u>	GB	<u>1, 14, 20,</u>
	<u>21, 24, 25, 30, 34, 40 (54), 43 (38), 52 (47), 57, 67</u>		
	40, 44		
	8, <u>12, 14, 17, 24</u>	CV	<u>3, 4, 5, 6,</u>
HT	1, 3, <u>7, 9</u>	HC	1, 3, <u>6, 7,</u>
	<u>8, 9</u>		
LV	1, <u>3, 4, 5, 8, 13, 14</u>	TH	1, 4, <u>5, 10,</u>
	14, 23		

SI 1, 3, 10, 11, 19
16, 20, 26

GV 1, 2, 4, 14,

iii) **Five Elements**

- 1) The pervasiveness of cycles through five stages or transformations of energy in nature, human life and the human body.
- 2) The Creative or Shen Cycle and Controlling or Ko Cycle.
- 3) Signs or symptoms of imbalance in the Elements in human health
- 4) The correspondences normally used in Five Element Theory, e.g. season, time

of day.

iv) **System of Meridian and/or Organ Theory**

There are various systems used in Shiatsu but for the baseline syllabus in addition to the mandatory Five Elements section, at least one of the following systems should be covered in depth as an integrated framework for understanding patterns of Ki in organs or meridians, diagnosis and treatment strategies:

- 1) Traditional Chinese Medicine
 - Zang Fu
 - Eight Principles
 - The Five Vital Substances
 - Six Divisions
 - Three Burners
 - Causes of disease
 - Understanding the philosophy of Shen, Yi, Po, Zhi and Hun.
- 2) Zen Shiatsu
 - Functions of the Meridians
 - Location of the extended (Zen) meridians
 - Kyo-Jitsu theory and usage
 - The six Makko-Ho meridian stretching exercises
 - Masunaga's stretches for the treatment of meridians
 - Hara and back diagnosis

v) **Diagnosis**

- 1) Visual
 - Distribution of Ki in the body
 - Posture
 - Gesture
 - Facial Hue
 - Movement
- 2) Touch
 - Knowledge of two of the following forms:
 - Meridian palpation
 - Masunaga hara and back diagnosis
 - Yu and Bo points
 - Pulse diagnosis

vi) **Giving Recommendations**

The practitioner should be able to give information to clients on how they can improve their health using means such as specific exercises and changes in diet and life style where appropriate.

vii) **Anatomy Physiology and Pathology**

- 1) Anatomy Syllabus
 - a) Skeletal system

- Students should know the names and location of the following bones:
- i) Skull: frontal, parietal, temporal, occipital, zygomatic, sphenoid, nasal, mandible, maxillae
 - ii) Spine: 7 cervical vertebrae, including atlas and axis
12 thoracic vertebrae
5 lumbar vertebrae
5 sacral vertebrae fused together to form the sacrum
3-4 coccygeal vertebrae
 - iii) Sternum and its tip, the xiphoid process
 - iv) Ribs: 12 pairs, including two pairs of floating ribs
 - v) Clavicles, scapulae
 - vi) Arm: humerus, radius, ulna, 8 carpal bones (not individual names), 5 metacarpals, 14 phalanges
 - vii) Hip: ilium, ischium, pubis
 - viii) Leg: femur, tibia, fibula, patella, 7 tarsal bones (not individual names), 5 metatarsals, 14 phalanges
- b) Joints**
- i) Basic structure of a synovial joint.
 - ii) The six types of synovial joints with examples of each and movements possible.
 - iii) Common example of cartilaginous and fibrous joints.
- c) Connective tissue**
Composition of connective tissue and most important types i.e. ligaments, tendons, fascia, cartilage, bone.
- d) Muscular system**
- i) The three types of muscles and where they are found
 - ii) Functional inter-relationship of muscles i.e. agonist / antagonist, synergist and fixators.
 - iii) Stretch reflexes and concept of stretching exercises (N.B. safety and effectiveness).
The names and position of the listed muscles below. Muscles which are highlighted and underlined should be studied more in depth i.e., students need to know action of highlighted muscles.
 - iv) Muscles that move the jaw: Masseter, temporalis
 - v) Muscles of the front and side of neck: Sternocleidomastoid
 - vi) Muscles of the torso:
 - 1) Back and neck: Erector spinae
 - 2) Muscles used in breathing: Diaphragm, internal and external intercostals
 - 3) Muscles of the anterior abdominal wall: Rectus abdominis, transverse abdominal, internal and external oblique
 - vii) Muscles that move the shoulder girdle: Pectoralis minor, Rhomboids, Levator scapulae, Trapezius
 - viii) Muscles that move the humerus: Pectoralis major, Deltoid, Latissimus dorsi
 - ix) Muscles that move the forearm: Biceps brachii, Triceps
 - x) Muscles that move the wrist and fingers: Anterior flexor group, posterior extensor group
 - xi) Muscles that move the thigh: Ilio psoas, Gluteus maximus, Gluteus medius, Gluteus minimus,

- xii) Lateral rotator group (including Piriformis)
- xiii) Muscles of the posterior thigh: Hamstrings (biceps femoris, semimembranosus, semitendinosus)
- xiv) Muscles of the medial thigh: Adductor group (including Adductor Magnus and Longus), Gracilis
- xv) Muscles of the anterior thigh: Quadriceps (rectus femoris and the three Vasti muscles)
- xvi) Muscles of the lower leg: Gastrocnemius, Soleus, Tibialis anterior and the Peroneus group.

2) Physiology Syllabus

Students are not required to have a knowledge of biochemical or histological details.

- a) Introduction
 - Brief description of cells and their functions, tissues, organs and systems.
 - Homeostasis and adaptation to the environment.
- b) Cardiovascular system
 - Anatomy of the Cardiovascular system. Function of the heart, arterial and venous systems. Composition of the blood and functions of its components.
- c) Lymphatic system
 - Anatomy and function of the Lymphatic system; introduction to the Immune System; anatomy and functions of the spleen.
- d) Respiratory system
 - Gross anatomy of the lungs, thoracic cage and pleura. Internal anatomy of lungs from the larynx and trachea to the bronchi, bronchioles and alveoli. Mechanics of breathing. Gaseous exchange and link with Cardiovascular system.
- e) Digestive system
 - Gross anatomy and functions of the oesophagus, stomach, duodenum, pancreas, small and large intestines and mesenteries. Physiology of absorption. Anatomy and functions of the liver, portal system and gall bladder.
- f) Urinary system
 - Gross anatomy of the kidney and bladder and their function of maintaining constant fluid and chemical levels in the body.
- g) Nervous system
 - Basic neuroanatomy – CNS: brain and the spinal cord; PNS: trunk nerves (including sciatic and femoral nerves) and the brachial plexus. Motor and sensory division. Autonomic Nervous System (ANS) anatomy and functions of Sympathetic and Parasympathetic systems.
- h) Endocrine system
 - Difference between endocrine and exocrine glands.
 - Description of the various glands and the functions of the hormones produced.
 - Control of the hormonal system by the hypothalamus via the pituitary gland.
 - Functions of the following hormones should be known: prolactin, luteinizing hormone (LH), follicle stimulating hormone (FSH), thyroxine, insulin, glucagons, hydrocortisone, adrenalin, oestrogen, progesterone and testosterone.
- i) Reproductive system
 - Female reproductive system:
 - Anatomy of female reproductive system
 - Egg production.

Menstrual cycle including hormonal control and changes in Uterus.
 Changes in anatomy, hormones and blood supply during pregnancy.
 Different stages in development of foetus.
 Stages of labour.

Male reproductive system:
 Anatomy of male reproductive system
 Production of sperm.
 Function of prostate gland.

- j) Sensory organs
 Basic anatomy and functioning of the eyes, tongue, nose, ears and skin.

3) Pathology Syllabus

For the following conditions, a short definition of each should be known, with knowledge of the main organ and / or systems involved and the main symptoms that arise. For example:

Hypothyroidism: is a subnormal activity of the thyroid gland. Adult onset symptoms are physical and mental slowing, undue sensitivity to cold, slowing of the pulse, weight gain and coarsening of the skin.

Ringworm: is a highly contagious fungal infection of the surface of the skin. The infection is ring-like and causes intense itching.

- a) Integumentary System
 Athletes foot, Psoriasis, Urticaria, Ringworm, Shingles, Dermatitis, Eczema, Acne, Warts/verrucae
- b) Skeletal System
 Ankylosing spondylitis, Gout, Kyphosis, Lordosis, Osteo-arthritis, Osteoporosis, Rheumatoid arthritis, Scoliosis
- c) Muscular System
 Bursitis (e.g. housemaids knee), Repetitive strain syndrome, Carpal tunnel syndrome, Tennis elbow, Frozen Shoulder, Strains (of muscles), Hernia (hiatus, femoral, inguinal, umbilical), Sprains
- d) Blood disorders
 Anaemia, haemophilia
- e) Cardiovascular System
 Aneurism, Angina pectoris, Shock, Arrhythmias (Tachycardia, Brachycardia, Atrial fibrillation), Arteriosclerosis, Coronary heart disease, Hypertension, Myocardial infarction, Thrombosis, Varicose veins, Haemorrhoids, Ischemia
- f) Respiratory System
 Asthma, Emphysema, Pleurisy, Respiratory tract infections (Laryngitis, Sinusitis, Bronchitis, Pneumonia), Pharyngitis
- g) Gastrointestinal System
 Appendicitis, Colitis, Hepatitis, Irritable Bowel Syndrome, Constipation, Diarrhea, Coeliac Disease, Diverticulitis, Colostomy/Ileostomy, Gallstones, Ulcers, Crohn's
- h) Renal System
 Cystitis, Urethritis, Kidney Stones
- i) Endocrine System
 Diabetes mellitus, Hyperthyroidism, Hypothyroidism
- j) Nervous System

- Brachial neuralgia, Epilepsy, Facial palsy, Meningitis, Migraine, Multiple sclerosis, Myalgic encephalomyelitis (ME), Parkinson's disease, Sciatica, Cerebrovascular accident
- k) Ear and eye
 - Menieres disease, Conjunctivitis, Tinnitus, Glaucoma
- l) Female Reproductive System
 - Amenorrhoea, Dysmenorrhoea, Menorrhagia, Eclampsia, Fibroids, knowledge of symptoms associated with Menopause, Premenstrual syndrome, Salpingitis, Vaginitis (e.g., Thrush), Infertility, Endometriosis
- m) Male Reproductive System
 - Impotence, Benign prostatic hypertrophy, Infertility
- n) Lymphatic and Immune System
 - AIDS, Glandular fever
- o) Miscellaneous
 - Cyst, Polyp, Allergy, Oedema, Inflammation, Iatrogenic, Tumour
- 4) **WARNINGS!**
 - Where clients should be advised to seek orthodox medicine:
 - a) Persistent high temperature
 - b) Undiagnosed lumps or swellings
 - c) Weeping and growing moles
 - d) Sudden loss or gain of weight for unknown reason
 - e) Bleeding from anus, urethra or vagina (other than menstrual)
 - f) Any symptom which persists for a long time or is getting worse (AP&P version 09/05)
- b) **PRINCIPLES of TOUCH**
 - i) Sensitivity to Ki and positive connection to the receiver's Ki
 - ii) Mental and physical focus
 - iii) Supportive touch
 - iv) Correctly angled pressure
 - v) Empathy and compassion for the receiver
 - vi) Posture and movement centred in the Hara
 - vii) Relaxed Pressure
 - viii) Continuity, appropriate pace and fluency of movement
- c) **TECHNIQUE**
 - i) Shiatsu in prone, supine, side and sitting positions
 - ii) Appropriate positions for giving Shiatsu during pregnancy or when there is restricted movement
 - iii) Accurate Meridian and Tsubo location
 - iv) Application of diagnosis in planning treatment.
- d) **CLIENT QUESTIONNAIRE**
 - i) How to fill in a client questionnaire
 - ii) How to construct a case study from this information. (You may wish to refer to the Society's guidelines for writing case studies for assessment. See 13)f).
- e) **CLIENT/ PRACTITIONER RELATIONSHIP**
 - Listening and Communication Skills
 - i) Basic skills such as non-judgmental listening, open and closed questioning,

- showing empathy
- ii) The client is encouraged to accept responsibility for his/her health and the direction and frequency of the sessions
 - iii) The practitioner can give clear feedback on the client's state of health
 - iv) The practitioner can give clear guidelines on planning future sessions
 - v) Clear communication of fees, working times, the nature of Shiatsu sessions and suitability of Shiatsu for particular clients
 - vi) Application of the Shiatsu Society (U.K.) Code of Professional Conduct and Ethics
 - vii) Knowledge of the Code of Professional Conduct and Ethics, the underlying ethical principles and its application in practice
- f) **SELF-AWARENESS and PERSONAL GROWTH**
A practitioner should:
- i) Have an understanding and diagnosis of their own health in terms of Shiatsu theory
 - ii) Have an awareness of their own emotional and psychological being, including areas which can be beneficially changed
 - iii) Be using practices to improve their own health such as physical and energetic systems of exercise, breath meditation, counseling and attention to diet and lifestyle
 - iv) Be using practices to increase awareness of Ki in self and others
 - v) Have received a course of at least six Shiatsu sessions with an M.R.S.S. practitioner
 - vi) Have received Shiatsu sessions from at least two other M.R.S.S. practitioners
- g) **PRACTICE MANAGEMENT**
- i) Punctuality, reliability and honesty in the professional relationship
 - ii) The setting up of a suitable environment for giving Shiatsu
 - iii) Hygiene as necessary in giving Shiatsu
 - iv) The keeping of clear records of all sessions
 - v) Maintaining records within the current legal framework. e.g. Data Protection legislation
 - vi) Maintaining appropriate insurance
 - vii) Awareness of taxation and National Insurance laws for self-employment
 - viii) Awareness of any legal issues pertaining to Shiatsu.
- h) **STUDY REQUIREMENTS**
- i) Study of Shiatsu (excluding anatomy, physiology and pathology and communication skills) for a minimum of 420 hours. For training commencing on or after 1st January 2002, the Baseline Syllabus to be covered over a minimum of 500 hours divided as follows: 440 hours Shiatsu theory and practice, 60 hours anatomy, physiology and pathology.
 - ii) Study over a minimum period of three years
 - iii) Study with 3 Shiatsu Society recognized teachers for a minimum of 24 hours with each teacher to develop an awareness of different approaches to Shiatsu.
 - iv) For training commencing on or after January 1st 2002 a minimum of 350 hours to be taught by Shiatsu Society Teachers (M.R.S.S.(T)).

28th April 2012

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Appendix 02 Shiatsu theory

Shiatsu draws on the theory underpinning Chinese medicine: namely 'Yin-Yang' and 'Five Element'. The theories of Yin-Yang and Five Element are complex and highly developed. However, there is only space within this study to give a synopsis of these theories to help set the cultural context and illustrate how they are linked to Shiatsu practice. Yin-Yang theory, Five Element theory, Zen Shiatsu and the concept of 'meridians' are outlined as follows.

Yin-Yang theory

Probably the single most important and distinctive theory of Chinese medicine is the concept of Yin-Yang which possibly dates back to about 700 BC (Maciocia 2005)⁴⁰. The theory postulates that all phenomena are an expression of Yin and Yang: an interdependent, continually-cycling duality (Maciocia 2005). The logic of the theory assumes that any one part of a phenomenon can be understood only in its relation to the whole and which can be both synthetic and dialectic (Kaptchuk 2000)⁴¹.

Yin and Yang represent two states in the process of change and transformation of phenomena; they change into each other and are relative. It is the alternation of Yin and Yang (the 'inner contradiction') (Maciocia 2005) that constitutes a motive force manifesting as 'Qi' or 'Chi' ('Ki' in Japan).

Underpinning the theory is the idea that 'Yin' corresponds to a more dense or substantial, contracting state, whereas 'Yang' corresponds to a relatively immaterial, non-substantial and expanding state. More specifically, the Chinese character for Yin originally meant the shady side of a slope. It is associated with

⁴⁰ Maciocia, G. (2005) *The Foundations of Chinese Medicine*, 2nd ed., Philadelphia: Churchill-Livingstone.

⁴¹ Kaptchuk, T. J. (2000) *The web that has no weaver: understanding Chinese Medicine*, London: McGraw-Hill.

the qualities such as 'cold, rest, responsiveness, passivity, darkness, interiority, downwardness, inwardness, decrease, satiation, tranquillity and quiescence' (Kaptchuk 2000). The original meaning of Yang on the other hand was the sunny side of a slope and implies brightness. Yang is associated with qualities such as 'heat, stimulation, movement, activity, excitement, vigour, light, exteriority, upwardness, outwardness and increase' (Kaptchuk 2000).

Yin-Yang theory influenced Chinese thought, culture and particularly in how phenomena were thought to occur independently of an external act of creation. Significantly, the idea of causation, central to Western thinking, is almost non-existent; instead, in Chinese thinking, events and phenomena 'unfold through a kind of spontaneous co-operation' (Kaptchuk 2000). Chinese thinking places importance on how 'things influence one another not by acts of mechanical causation, but by a kind of 'inductance' ... the key-word in Chinese thought is 'Order' and above all 'Pattern' ...' (Needham 1956 cited in Kaptchuk 2000)⁴².

In Chinese medicine, all physiological processes are considered to be a result of the opposition and interdependence of Yin and Yang. It is postulated that physiological imbalances can occur through the adverse effects of internal or external factors (for example, food, environment, behaviour). As such, Chinese medicine seeks to restore a balance of health through intervention (for example, herbs, Acupuncture, bodywork).

Five Element theory

Stemming from Chinese philosophy and first systemised around 300 BCE (Jarmey and Mojay 1999), 'Five Element' theory is more accurately translated as 'five phases' from the Chinese term Wu Xing (Kaptchuk 2000). 'Wu' is translated as 'five' as 'Xing' as 'move' or 'walk' or more accurately it implies a process.

⁴² Needham, J. (1956) *Science and Civilization in China*, Vol. 2, Cambridge: Cambridge University Press.

Beresford-Cooke (2003) refers to a literal translation as the 'Five Walkings'. The five phases refer to a dynamic system of correspondences and patterns that is used to classify all phenomena (for example, season, colour, emotion) in terms of five quintessential processes represented by the emblems Wood, Fire, Earth, Metal and Water. The emblems express the energetic quality of phenomena; they interconnect, both arising out of and controlling each other.

The energetic qualities of the Wood phase are associated with growth. The Fire phase is depicted as having reached a maximal state of activity and the turning point towards Metal which is associated with a declining state. The Water phase represents a maximal state of rest and the turning point towards the growth phase of Wood. The Earth is a buffer between the phases although sometimes depicted as being the phase between Fire and Metal. In concrete terms, the Five Phases can be used to describe the annual cycle of seasons in terms of biological growth, development and decline.

As an energetic system based on intuitive insight and logic, it provides a tool to make sense of health in physical, psychological and spiritual terms.

Zen Shiatsu

As discussed in Chapter 2, there are many styles of Shiatsu but the style adopted mostly in the UK and which is taught by UK Shiatsu training schools is largely based on Zen Shiatsu theory and practice.

Attributed to Shizuto Masunaga (1925-1981), Zen Shiatsu practice involves the practitioner being at one with the person receiving Shiatsu by developing a Zen-like quality of concentration requiring a development of mu-shin or innocent mind (no ego) (Kishi and Whieldon 2011). According to Kishi and Whieldon (2011), this

is an active process and not to be confused with meditation; Shiatsu is performed with this empty mind rather than from theory.

Meridians

Masunaga and Ohashi (1977) suggest that 'meridians' are the 'imaginary lines' that connect the Acupuncture points (tsubos) on the skin (p. 21). According to Kaptchuk (2000) the word 'meridian' entered the English language via the French translation of the Chinese term 'jing-luo' where 'jing' means 'to go through' or 'thread in a fabric'; 'luo' means 'something that connects or attaches' or 'net' (p. 105). Kaptchuk (2000) suggests that 'meridians' are the 'channels or pathways that carry the Qi and Blood⁴³ through the body (p. 105). They are not blood vessels but more a kind of 'invisible lattice that links together all the fundamental textures and organs' (Kaptchuk 2000) .

⁴³ Qi (life force) and Blood are two of the five 'vital substances' in Chinese medicine



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Appendix 03 Participant information leaflet

You are invited to participate in the following research study:

An exploration into the expectations and challenges experienced by Shiatsu practitioners

This study is being carried out by:

Sue Spurr, PhD student. Tel [REDACTED] Email: [REDACTED]
Faculty of Health & Social Care, The Open University, Walton, Hall, Milton Keynes,
MK7 6AA.

This research has been approved by the Open University ethics research committee. I will follow professional research codes of conducts as stipulated by the British Sociological Association (BSA) ethics guidelines.

This information leaflet provides details on why the research is being carried out and what is involved. Before you agree to take part in this study, please take time to read the information on this leaflet and get in touch with me if you have any questions.

What is the purpose of the study?

The focus of this research is to explore your experiences and challenges of being a Shiatsu practitioner in the UK.

This research is being carried out in relation to gaining a better understanding of the wider issues around professionalisation and regulation.

This research will be useful for all Complementary and Alternative Medicine (CAM) professionals as well as professional and regulatory bodies, training organisations and commissioners of healthcare. It will contribute to the wider debates on healthcare.

What happens if you take part?

I will record your experiences as a Shiatsu practitioner during the period May 2011 and March 2013.

You can take part in all or any of the following stages (i) - (iii) below:

- (i) A face-to-face interview between you and me - which will take place at mutually agreed time and venue - about your experiences of being a Shiatsu practitioner.

- (ii) I will observe up to six Shiatsu practice classes/workshops/meetings as and when they take place;
- (iii) I will observe up to six practitioners in their workplace at a mutually agreed time and venue.

What happens to the information you disclose?
 With your permission, I will record using a digital recorder the interview and this recording will later be transcribed. I will ensure that you have the opportunity to read the transcript(s) and submit comments to me if you wish. You are also welcome to contact me at any time if you have questions about the research. Any information you disclose will remain confidential and all identities will be anonymised.

All information relating to recorded conversations will be stored in accordance with Data Protection and Freedom of Information Acts and equal opportunities legislation. Any data stored will be stored until one year after the end of the project and then destroyed. You have the right to ask for a copy of any personal data held in relation to you and this research study and no one else has this right. You do not have the right to any view other participant's data.

At the end of the study, the results will be written up as a PhD thesis. You will be sent a report summarising the findings and/or recommendations, plans for dissemination and references to other publications.

Can you withdraw your participation?
 You can withdraw your participation at any time during the course of the study. Any information you have given prior to your withdrawal will be destroyed unless you give your permission for it to be used.

Recompense
 You will be recompensed all reasonable expenses.

Who is organising this research?
 The research is being undertaken by Sue Spurr with supervision by Professor Jan Draper and Dr Maxine Birch, Faculty of Health & Social Care, at the Open University. If you wish to make a complaint in relation to this research, you may contact Dr Lindsay O'Dell, Director of Postgraduate Research, Faculty of Health & Social Care, The Open University, email: l.odell@open.ac.uk

Contacts for further information:
 Please do not hesitate to get in touch with either me or my supervisors if you have queries in relation to this study. My supervisors are

Professor Jan Draper:	Dr Maxine Birch
Email: [redacted]	Email: [redacted]

Thank you for taking the time to read this leaflet.

If you are willing to participate in this research study, please complete and sign the enclosed form entitled 'Agreement to participate' and return to Sue Spurr using the pre-paid address label supplied. On receipt of your signed form, I will be in touch to discuss your participation further.

Please remember to keep this information leaflet.



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Appendix 04 Agreement to Participate

An exploration into the expectations and challenges experienced by Shiatsu practitioners

(the project)

I, (print name)

agree to take part in this research project.

- I have read the information leaflet and had the purposes of the research project explained to me.
- I have been informed that I may refuse to participate at any point by simply saying so.
- I have been assured that my confidentiality will be protected as specified in the leaflet.
- I agree that the information that I provide can be used for educational or research purposes, including publication.

I understand that if I have any concerns or difficulties I can contact:

(name of the researcher)

at: Faculty of Health & Social Care
The Open University
Walton Hall
Milton Keynes MK7 6AA

Email:

If I want to talk to someone else about this project, I can contact:

Dr Lindsay O'Dell
Director of Postgraduate Studies

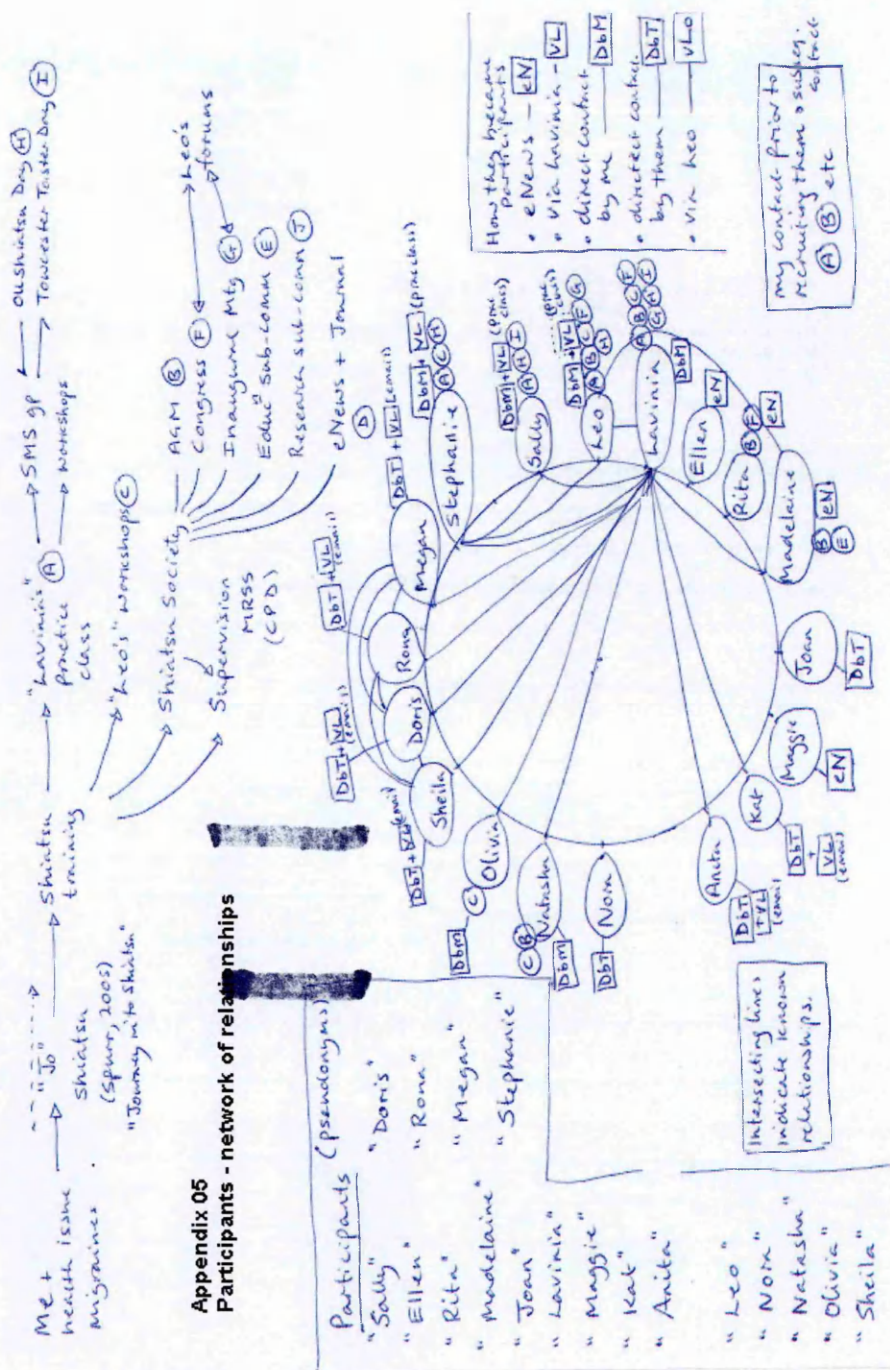
Email:

I assign the copyright for my contribution to the Faculty for use in education, research or publication.

Signed:

Date:

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Appendix 06 The inaugural meeting 'Campaign for Shiatsu'

Fieldnote

I decided that this meeting would be an interesting one to attend as part of my research and possibly be an opportunity to recruit participants. Leo who I had met once at one of his workshops, appeared to be one of the prime instigators of the campaign and described the aims as follows:

- a) to promote Shiatsu to be as well-known and respected as Acupuncture
- b) to explain Shiatsu in a way that everyone can understand
- c) to form Local Action Groups that act as mutual support and as local promotion teams
- d) to raise the morale and confidence of practitioners.

(Leo 26 March 2011)

The aim of the inaugural meeting was to discuss and agree an action plan for implementing these aims. It had been advertised among the Shiatsu community by Leo via email a few weeks before the date the meeting was due to take place. In his email Leo wrote:

'The point of this meeting is:

- 1) to decide on coordinated actions and promotions later in the year
- 2) to report on and hear news from Local Action groups
- 3) to make proposals for specific funding and support to the Shiatsu Society

Can you let me know if you are going to attend.'

(Leo 8 March, 2011)

Prior to the meeting I'd contacted Leo by email (14 March 2011) to ask if he would be happy for me to tell everyone who turned up about my research and invite them to become participants. I also asked him if it would be possible for me to observe the meeting and take notes. He had no objections. I arrived at the venue early, made a cup of tea in the small kitchen, removed my shoes as is customary in the Shiatsu world, and ventured upstairs to where the meeting would take place. There was no one else there. I pondered on where I should sit. I guessed we would be sitting on the floor in a circle. I decided to wait and play it by ear. When Leo arrived he greeted me warmly. I checked to make sure that he was still happy for me to observe and take notes. He said 'Fine' but added 'It isn't a 'touchy-feely' meeting but a business meeting'. I wasn't quite sure what he meant but made no comment. He added that I should ask the people who attended the meeting for their permission to take notes.

Other people started to arrive and eventually there were twelve people in all, some of whom were familiar faces. Leo invited us all to sit down and, as I'd anticipated, we formed a circle on the floor, which, like taking one's shoes off at the entrance, is customary practice. In the end I decided to situate myself so that I was part of the circle as it felt slightly odd to remain outside of it but I still needed to keep the 'familiar strange'. We introduced ourselves and when it came to my turn, I chose this point to explain briefly my research and asked everyone if they would be willing for me to observe and take notes, reassuring them that all identities would be protected. There were nods of consent and one or two murmured how they thought my research was important and interesting. It didn't

feel quite right at this point to hand out my information leaflets and 'agreement to participate forms'. I decided to wait until the end of the meeting.

I had taken a laptop to take notes. I noticed that Leo also had his laptop to which he referred now and again. Taking my laptop was an experiment and I wasn't sure how it would work. On the one hand, it felt as if I was making my presence more obvious, perhaps just being transparent, but on the other hand it felt a bit intrusive. On balance, I wasn't that comfortable with it as it felt slightly odd not keeping eye contact or at least some sort of focus in the room and while it might save time writing up notes later, handwriting notes into a note book was possibly more comfortable. Nonetheless, I continued with making notes on my laptop on this occasion.

During the meeting, unless I was specifically asked a question, I made no comment. This was a deliberate approach on my part as I wanted to keep the focus of what I was doing at the meeting as me-as-researcher not me-as-practitioner. I immersed myself in making notes of my observations and became quite surprised how comfortable I felt doing this, how quickly the time went and how easy it was to describe what was happening. At one point, the person on my left who was very actively involved during the meeting (ie speaking quite a lot) commented on how detailed my notes were. I realised at this point that she had probably been reading everything I was writing! As this person was particularly vocal I felt quite confident that of all the people present, she was probably the most likely to object and therefore by virtue of her not objecting to my note-taking and/or notes, I felt reassured that it was not a problem me being there in my capacity as a researcher. In effect, it felt almost as if I had passed a sort of test with the result that I didn't feel like an intruder but part of it.

The meeting closed at about 7.45pm and it soon became a bit chaotic as people started to hurry off to catch their trains. I quickly began to hand out my information leaflets and agreement to participant forms but it felt as if I'd missed the wave, and although people politely took my leaflets, I could sense their focus was on their journey home. There was no further opportunity to stand and talk and I resigned myself to having lost the opportunity to recruit any participants.

But then the Shiatsu Society administrator, who had been present at the meeting, asked if anyone was walking to the tube as she was unhappy about walking on her own in the dark. A couple of us offered to walk with her which turned out to have a productive outcome. We all caught the same tube and the administrator and I ended up at the same mainline station and then by chance on the same train out of London. Once on the train and seated, I offered her one of my sandwiches and she seemed glad of it. She asked about my research and appeared to be genuinely interested. I gave her one of my leaflets and she offered to post a note to the Shiatsu Society eNews⁴⁴ suggesting that anyone who would like to participate in my research should get in touch with me.

⁴⁴ Newsletter that is sent about every fortnight to members of the Shiatsu Society by email

Appendix 07 Reflection: taking notes as a practitioner

In my practise as a Shiatsu practitioner, sometimes I return to my notes a few hours later and add more as things occurs to me. The above strategy for client note-taking is now embedded in my practice. I feel that on balance, although I may lose some of the detail of my observations and conversations by not writing things down at the time, the encounter is richer as I feel that people tend to talk with greater ease and which seems to allow them to remember issues or to speak more about the things that are bothering them – often matters which I might have passed over as they didn't seem to be important to me. By not interrupting the flow by writing things down as they happened, I can sense more easily when to hold the silences and allow space, when to probe or not. By not saying much, by staying quite still and encouraging clients to point to where they might have pain we jointly find the starting point for the bodywork. Bodywork then becomes an extension of this process and is often carried out in silence. During the bodywork, people do not often talk much but sometimes they begin to speak after a while. For example, part-way through a treatment, having not spoken for a while, people might suddenly say something like 'Oh yes, I forgot, another thing is that I broke my leg in a car accident a few years ago'. It's as if the experience and emotion were embodied and somehow released through bodywork. When I write up my notes of the session, I revisit the bodywork in my mind and use this to remind me what to record.

Appendix 08 Summary of participants' characteristics

Key to colours			
Students	Practitioners just graduated by up to 2 years	Practitioners graduated between 10 and 15 years	Practitioners/teachers between 15 and 40 years

Pseudonym	Practitioner status at point of interview	Interview F2F/tel	Experiences/influences/challenges
Nora	Student – just starting training; early 30s	F2F	'it wasn't a necessarily considered and academic decision it was a ... whole body decision .. and I wanted a career ... not even a career just a way of life which um reflected my values'
Rona	2nd year student; early 40s	F2F	'Oh actually I probably am later on in life now and it's time to sort of start training in it'
Anita	3rd year student; late 50s	F2F	' I got tired of starting things and then having to let everybody down so I thought the best thing to do would be self-employed'
Megan	3rd year student; early 20s	F2F (with Doris)	' kind of have like a goal since I was like 9 or something to um to work in beauty and that kind of industry ... and I kind of got interested in Shiatsu and Reiki and all these other things'
Sheila	3rd year student; early 30s	F2F	'What skill can I learn that's gonna be really well accepted?'
Doris	3rd year student; early 20s	F2F (with Megan)	'I was interested in complementary therapies ... and what I really liked about Shiatsu was that there was a strong focus on self-development'
Kat	Student just graduate; early 20s.	F2F	'I was looking for uni courses and I knew I wanted to do something with complementary therapies'
Joan	Practitioner – newly qualified; late 50s	F2F	'I might as well tie it up with a degree 'cos a degree is something I've always wanted to do and never did 'cos I left school at 15'
Stephanie	Practitioner - newly qualified; circa 50	F2F	' the lady teaching that course [Yoga] was actually a Shiatsu practitioner ... so that just really got me sort of interested'
Ellen	Practitioner – qualified 2 years; circa late 30s	Tel	'I went on a Buddhist retreat ... I thought 'Oh my goodness you know maybe I can do more about this is ... another way of approaching this problem'
Me	Practitioner – qualified 2008;		'If Shiatsu could provide relief from the attacks of migraines even if it didn't prevent them this was worth pursuing'

Rita	Practitioner – qualified 1 year; circa 50	Tel/F2F	'I'd gone on from reflexology to Massage and during that training the tutor happened to say to me one day 'Oh you'd love the Shiatsu training 'cos you do meditation and Tai Chi and things like that' all stuff that's sort of up my street'
Maggie	Practitioner – qualified about 15 years; late 50s	Tel	'decided the proper job was hard work, Shiatsu was far more important'
Olivia	Practitioner – qualified 10 years; late 40s	F2F	'I'd always kind of been interested in another way of looking at health anyway probably you know a bit of an alternative thinker anyway'
Sally	Practitioner – qualified 10 years; late 50s	F2F	' when I look back I see this whole pattern of moving starting off with this realisation that I needed wanted control over my own life and my children and so on and um in health terms only of course'
Natasha	Practitioner /teacher; trained in mid-80s early; 50s	F2F	'it was kind of being with people who weren't frightened but were not trying to control the thing but actually support your individual journey and that was massive for me'
Madelaine	Practitioner /teacher; runs own school plus comp therapies centre; trained in early 1980s; late 50s;	Tel	'I felt I was young and healthy and fit when I started but by the end weekend I felt fantastic and I thought Oh there is something going on here'
Lavinia	Practitioner /teacher; trained in mid- 1980s; early 50s	F2F	'gave me weekly Shiatsu for a while and it really helped me get much stronger and get back on track and after that I was almost converted and I just knew that um ... I wanted to learn more and find out more about it'
Leo	Practitioner/teacher; runs own school; Associated with Shiatsu (40 years); late 50s	F2F	'just a door opened ... there was a whole connection to Chinese medicine and um stuff like that so I suddenly thought this is something that's worth studying not just something I know how to do'

Appendix 09 Sitting in a circle

Sitting on the floor in a circle is a common Shiatsu social practice as illustrated by Kishi and Whieldon (2011) in their description of the start of a Shiatsu gathering:

[we] sat, relaxed with 30 or so other participants in a circle around the room (p. 5).

My fieldnote from a training weekend illustrates my observations in this respect.

Fieldnote

Training weekend, day one November 2011

Arranged in a circle on the oak-boarded floor were thin black futons.

Some people were already seating themselves on the floor, some having sought out a cushion from a pile in an alcove by the swing door. There was quiet conversation going on.

Eventually, when everyone was seated on cushions, cross-legged or kneeling as is the practice at the start of a session, Leo (who was sitting under the huge mirror) started to look around the room and we fell silent.

'Please introduce yourselves as an expression of how you are feeling rather than what you'd like to learn about'.

Despite all my reservations and the threat of a developing sore throat, it was mostly a good feeling I had; I was intrigued by what was to come. I was acutely aware of so many people I didn't know – there were 21 of us. I could feel my energy sapping and an increasing sense of being disconnected from my body and being 'all in my head'. We didn't go round systemically in the circle but each person spoke when they felt like it.

There was respectfulness in the room – a listening quality in the atmosphere. Many people said they were tired. Many people also spoke of being nervous especially people for whom English was not their first language (there was a French person, someone from Spain and a German). Quite a few people had been on Leo's courses before. It seemed that it was expected everyone would say something at some point. It felt like a very trusted space and through this I found the energy and confidence to speak. I was surprised at how I managed to speak and the feeling of relief when I had spoken.

Appendix 10 Joan and Sally's Shiatsu spaces

Fieldnote

Joan's Shiatsu space

The Cancer Care Centre was on the third floor of a tall, modern building that had previously been used as an open plan office in the middle of a medium-sized northern town. The space was divided into rooms by thin, floor to ceiling partitioning and which afforded some privacy. Each room had its own entrance and name. As I walked into the centre with Joan, people greeted us both warmly. The place was light and airy and clean, having been recently re-furnished. As Joan showed me round introducing me to her colleagues, people clearly knew and liked Joan. Eventually we entered Joan's space. It was lit naturally by a large window that overlooked the hills in the distance beyond the town. Joan invited me to sit in a comfortable chair and she sat opposite me. Between us was a low table with leaflets, a vase of fresh flowers and a CD player. Dressed in a white tunic and dark coloured trousers, Joan looked relaxed and her presence somehow put me at ease too. A treatment 'bed' stood centre stage to our side. It was covered in a spotless white cover; a small oblong head cushion lay at one end of the bed, neatly folded blanket at the other. In one corner, a set of pastel coloured towels were stacked carefully on a set of shelves mounted on the wall. A green futon lay under the shelves. The room had a spacious, clean, calm and orderly feel. There was a slight smell of incense or scented candle.

Fieldnote

Sally's Shiatsu space

Sally practised Shiatsu and Acupuncture a small village within a very rural setting. She rented what had previously been a GP's surgery comprising two

small rooms at the end of a row old of terraced houses. The front door opened directly into a waiting area – a welcoming space – with sufficient chairs for two or three people and a table with leaflets. A small window enabled one to look out onto the cottage gardens. A small door led to a toilet at one corner. Directly opposite the front door was a door which led to the treatment room where a futon was rolled up neatly to one side. A window opened onto the street where very few cars passed. It was neat, clean and felt quiet and welcoming. We sat and spoke in what felt like a very welcoming space.